We speak for the dead to protect the living.

Domestic Violence Death Review Committee

Annual Report to the Chief Coroner: 2004

Submitted by the DVDRC Chair:
Al J.C. O'Marra, B.A., M.A., LL.B., LL.M.

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Chapter 1 – Introduction and Report Overview

The Domestic Violence Death Review Committee (DVDRC) is a multi-disciplinary advisory committee of experts, established under the authority of the Coroners Act[1], that reports the results of domestic violence fatality investigations to the Chief Coroner. In 2003, the committee presented the first annual report to the Chief Coroner of cases occurring during the year 2002. Since then, the committee has continued reviewing and reporting on cases that have occurred between the years 2002 and 2004. An average of 26 homicide cases per year occurred between 2002 and 2004, with an average of 34 deaths. However, the number of reviews conducted each year represents less than half of all domestic violence cases.

When it was first formed, the committee determined that it would review cases only when they had been completed before the courts, or when there was no accused because the perpetrator had died as well. In the first report, we reviewed and reported on 11 occurrences and 24 fatalities—eight of the cases were homicide–suicides and two of the cases had multiple homicides. This report reviews nine occurrences and 11 fatalities, only two of which were homicide–suicides. However, our statistical analysis of antecedent information about the victims and perpetrators, used to help identify risk factors in these kinds of fatalities, is cumulative.

As with the previous review, women are predominantly the primary victims[2] in these cases. In eight of the nine cases, the perpetrator was male. Of the nine cases, four involved child custody and access disputes, an issue not identified in our last review report. In addition, two of the homicides involved non-custodial parents murdering their children. The reviews have become increasingly more complex, particularly with respect to those cases involving perpetrators killing children of the relationship and those with multiple system involvement, such as criminal and family justice, child welfare protection, and health services.

An important concern to the DVDRC as a result of our review is the extent to which these homicides appear both predictable and preventable, based on an analysis of well-known risk factors. In eight out of nine cases, the homicide appeared both predictable and preventable. In the majority of cases reviewed, ten or more risk factors associated with potentially lethal violence were present in the circumstances.

[1] Section 15 (4) of the Coroners Act, R.S.O. 1990, c.37, as amended

[2] "Primary victim" is the intended target of the domestic violence, the partner or ex-partner, although in two instances the deceased were children whose deaths were the result of the violence in the lives of their parents.

a. Purpose of the DVDRC

The purpose of the committee, as outlined in its Terms of Reference, is to assist the Office of the Chief Coroner of Ontario in investigating and reviewing deaths of persons that occur as a result of domestic violence, and making recommendations to help prevent such deaths in the future. Initially, the cases referred to the committee were all homicides involving the death of a person and/or her or his child(ren), committed by the person's partner or ex-partner from an intimate relationship. We have expanded the terms of reference with respect to the cases referred to the committee to include those occurrences where there has been a failed attempt on the life of the primary victim and his/her child(ren) and where the perpetrator had died, either by suicide or homicide.

The mandate of the committee is to help reduce domestic violence generally, and domestic homicides in particular, by:

- thoroughly reviewing all intimate partner and ex-partner homicides;
- identifying systemic issues, problems, gaps, or shortcomings of each case and making recommendations to address these concerns;
- creating and maintaining a comprehensive database about the perpetrators and victims of domestic violence fatalities and their circumstances;
- helping to identify trends, risk factors, and patterns from the cases reviewed to make recommendations for effective intervention and prevention strategies;
- reporting annually on domestic violence fatalities to enhance public understanding and awareness of the issues, and conducting and promoting further research where appropriate.

Between 1998 and 2002, three major coroner's inquests into domestic violence-related killings have been held in the province of Ontario. The first inquest was held in 1998, and focused on the deaths of Arlene May and Randy Iles. May was killed by her estranged boyfriend, Randy, who then committed suicide. During more than four months of testimony, jurors heard from 76 witnesses and returned with 213 recommendations intended to make the system more responsive to the needs of women and children experiencing domestic violence. The second inquest, held in January 2001, examined the events leading up to the domestic homicide of the Luft family of Kitchener. In July 2000, William (Bill) Luft killed his wife, Bohumila, and their four children before taking his own life. The most recent inquest was held between October 2001 and February 2002, after the domestic homicide–suicide of Gillian and Ralph Hadley of Pickering in June the previous year.

The major themes emerging from these inquests on domestic violence include:

- Improve mechanisms for communication among and coordination of domestic violence resources and responses;
- Provide more effective education and training on domestic violence for every sector of the response system;
- Ensure access to essential services for victims, their batterers, and their families, especially children exposed to domestic violence;
- Ensure adequate funding for community-based violence against women services;

- Implement standardized risk assessment and safety planning tools across the system in Ontario;
- Conduct ongoing research to more fully understand the circumstances leading to domestic violence fatalities and the responses to it.

b. Why is there a need for a DVDRC process?

Our review and assessment of cases continues to re-enforce the perspective that these themes emerging from inquests are still valid. There is a continuing need to address each of them if we are to achieve the goal of preventing deaths in similar circumstances.

Such reviews, whether by inquest or committee reviews, are necessary to answer the question of "why" deaths from domestic violence occur. Trying to answer the question of "why" is essential in any process directed to prevention. Generally, death investigations are directed to answering who died, when and where it happened, what the cause of death was, and whether it was as a result of homicide, suicide, accident, natural causes, or undetermined. But to answer why the death occurred and what can be done to prevent it in the future requires a more extensive inquiry into the constellation of circumstances that lead to the death.

When deaths result from accidents or even natural causes, as a society we ask why the death occurred. When someone dies in a motor vehicle collision, we ask whether there was a problem with the driver or the road conditions, or a failure of some part of the vehicle. When there is an airplane crash, in addition to inquiring whether there was pilot error, there is a complete systems analysis[3] to determine whether there was some flaw in the craft or other systemic conditions that contributed to the failure or error leading to the disaster and deaths. Such disasters, usually resulting in a massive number of fatalities, lead to some form of inquiry directed to trying to answer why it happened. Similarly, hospitals continuously engage in morbidity and mortality reviews. They increasingly apply the same kind of systems analysis developed in the aeronautics industry to determine whether the management of the patient's malady or course of treatment could be improved. To make the necessary changes to avoid such deaths in the future, the overarching question in these inquiries has to be, Why did the death occur?

However, when the fatality results from domestic violence, the question is rarely asked from a systemic paradigm. Undoubtedly, nothing is more complex and difficult to understand than human relations. In the context of trying to understand the circumstances that lead to these kinds of fatalities, inquests such as the ones mentioned above have

[3]The systems approach is an analytical method used in the study of why adverse events occur. The fundamental premise of the systems approach is that humans will make errors in even the best organizations. These errors are recognized as the consequences of problems that predate the errors. Thus, to reduce the number of errors, changes must be made to the workplace or the system. Adverse events occur because of either active failures on the part of individuals, or latent conditions within the system or process that contribute to or create the circumstance where the error occurs. Active failures include unsafe acts committed by people who are in direct contact with the patient, such as slips, lapses, fumbles, mistakes, and procedural violations, without assigning blame or finding fault. Latent conditions comprise the underlying system factors that contribute to the potential for active failures.
Dr. James Reason, *Human Error: Models and Management*, BMJ, 2000;320:768–70.

helped to some limited extent in addressing the question "why." While each of these lengthy and costly inquests resulted in a number of important recommendations, there continue to be a significant number of such fatalities in Ontario from which more could be learned. However, without a significant realignment of resources, it is impossible to conduct such extensive inquiries in all such fatalities. Alternatively, only by intensively examining the circumstances of these deaths, with the benefit of the various expert perspectives represented on committees such as the DVDRC, can we try to learn as much as possible in trying to answer "why."

In the context of domestic violence fatality reviews, the deaths being examined are always first and foremost attributable to the actions of the perpetrator. In addressing the question "why," however, the application of a non-fault finding systems analysis assists in the examination of those systems—such as justice, health, and social services—with which the victims and perpetrators were involved prior to the fatalities.

c. Case Reviews and Recommendations

In our first report, we found that the issues identified and the resultant recommendations fell into one of three broad categories. Our review of the cases forming the basis of this report can again be grouped into the same categories:

- awareness and education
- assessment and intervention
- need for resources

Firstly, there continues to be a need to generally heighten awareness and provide education about domestic violence. Also, it is important to ensure that domestic violence education and awareness work be done in a culturally competent manner[4], using multiple strategies and approaches. Ontario is the most racially, ethnically, and linguistically diverse province in Canada. Therefore, all public education should strive to meet and impact the broadest possible audience. In every case reviewed, family members, friends, neighbours, co-workers, and/or professionals had some knowledge of the escalating circumstances between the perpetrators and victims. However, these individuals did not appreciate the significance of the situation, the information or warning signs available to them, or what to do about it. Accordingly, many of the recommendations address the need for targeted public awareness and professional educational programs that teach about the signs of domestic violence and the risk factors leading to potentially lethal consequences.

Secondly, there is a need to have appropriate tools available to those who work with victims and perpetrators of domestic violence to better assess the potential for lethal violence in their lives, and corresponding access to appropriate services and programs. As

[4] "Cultural Competence" is a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals that enable effective work in cross-cultural situations. "Culture" refers to integrated patterns of human behaviour that include language, racial, ethnic, religion, or social groups. "Competence" implies having the capacity to function effectively as an individual and an organization within the context of cultural beliefs, behaviours, and needs presented by consumers and their communities. (Cross, T. et al., 1989)

an example, victims may need access to safety planning and perpetrators may benefit from access to counselling programs.

Thirdly, adequate resources are required to institute programs that will help to ensure victim safety and reduce the perpetrator's risk.

Awareness and Education:

While there may be increasing public awareness and professional training concerning domestic violence, the cases we reviewed this year highlight the need to expand this awareness and training and make the necessary links to appropriate action. In many of the cases we reviewed, the indicators for domestic violence were present and even recognized. However, there seemed to be a lack of referrals and/or interventions which focused on safety planning for victims and treatment or other programs for perpetrators.

In the majority of the reviewed cases, there were ten or more risk factors associated with potentially lethal violence present in the circumstances. Throughout our case reviews, we identified multiple opportunities for intervention by family, friends, co-workers, and employers. More importantly, front-line professionals such as family doctors, lawyers, and child welfare and protection workers, as well as more specialized domestic violence services such as police and shelters for abused women also had opportunities for intervention.

Many of the recommendations in this section address the need for ongoing training of professionals to not only identify the risk of violence in the lives of those they deal with, but also what to do about it. Once the risk is identified, the professional, child protection worker, co-worker, or employer has to know how to effectively intervene with the appropriate referrals. Simply put: if you can say when it is likely to occur, you should also know what to do about it.

Assessment and Intervention:

Last year, the committee reported on the need to have appropriate risk assessment tools for use by those who deal with victims and perpetrators of domestic violence to identify those who have a high likelihood to act violently. We note that a pilot project involving the use of the *Ontario Domestic Assault Risk Assessment* (ODARA) tool has started in two jurisdictions, and the *Domestic Violence Supplementary Response* form continues to be used by police services throughout the province. If individuals charged with offences involving domestic violence and considered high risk as a result of an assessment are released, there needs to be continuing vigilance and follow-up if breaches occur. Recommendations in this area focus on the need for police services to institute dedicated high-risk case management units to supervise and monitor the case until completion.

A number of the cases we examined involved bail releases. It was apparent that the sureties in several of these cases were inappropriate for many reasons, including:

- having criminal records;
- giving false identities and being approved without adequate checks;

- being unable or unwilling to exercise control over the accused;
- failing to contact the police when the accused became non-compliant with conditions;
- actively facilitating breaches; and
- generally displaying a lack of appreciation or caring about the consequences of failing to meet the obligations of being a surety.

Several of the recommendations address the need to ensure that sureties are appropriate to the seriousness of the undertaking.

As the concept of risk assessment becomes better understood, the committee feels it is important for community professionals to recognize that these assessments should not be limited to use by professionals involved in the criminal justice system. Every sector needs to use these tools when clients reveal domestic violence in their lives. Healthcare providers in hospital and community settings are well placed to gather critical information after victims or perpetrators present physical injuries or mental distress as symptoms. As well, shelters should adopt the use of standardized risk assessment tools for intake so those who require immediate assistance receive it.

Two of the cases reviewed involved a parent killing children as a form of punishment or revenge against the other partner during the separation. Several of the recommendations are directed to the need for child welfare and protection services to use a domestic violence assessment process that takes into account the dynamics of the violence in the family. A number of other recommendations address the need for a greater understanding by police about the enforcement of Family Court Orders. There is also recognition of the need for greater communication between the criminal justice and family law process. Further, there are recommendations directed to the need for Family Court judges to have assessment reports prepared by qualified assessors with domestic violence training available to them when deciding matters of child access—particularly in cases were one of the parties has a history of domestic violence.

Need for Resources:

As noted in last year's report, and it bears repeating, adequate resources are required to ensure victim safety and reduce perpetrator risk. All programming and services require resources to become operational. These resources include, but are not limited to:

- helping the victim to be removed from the situation;
- providing affordable and accessible alternative housing;
- providing counselling services for victims and families;
- providing other community-based support systems for victims and perpetrators and children exposed to domestic violence.

One of the cases reviewed this year highlighted the need for adequate resources to provide access to these kinds of services and responses in northern and more remote or rural areas. Of particular concern in this year's review is the need for resources to train and provide the tools for those engaged in protecting children where there is violence in the lives of their parents.

d. Statistical Analysis

In 2004, the DVDRC reviewed nine domestic violence cases involving homicides. There were 11 deaths, since two of the cases involved a homicide-suicide. Two of the cases involved homicides of toddlers by their fathers who were targeting their estranged spouse by killing their child. Both of these cases involved criminal and family court proceedings in which there were criminal charges and conflict over access to children. The majority of homicides involved married couples who were Canadian citizens with children. Eight of the nine cases involved male perpetrators. In the one case of a female perpetrator and male victim, there had been a previous history of his violence in the context of this intimate relationship.

In our second year, we were able to review current cases as well as combine data with the previous year, which produced a more sizable total of 20 cases. In our analysis, we found common risk factors associated with the domestic violence and risk assessments literature. The most common factors found in the nine cases reviewed in 2004 as well as the overall common factors for 2003 and 2004 combined appear to be an actual or pending separation, prior history of domestic violence, and a perpetrator who had made threats to harm himself or his partner in the past. A history of depression, alcohol abuse, and stalking behaviour appear to be present in at least half of the cases. Four of the nine cases in 2004 involved child custody and access disputes, in contrast to this issue not being identified in our 2003 review.

An important concern to the DVDRC is the extent to which the homicides reviewed appear predictable and preventable with the benefit of hindsight and the analysis of well-known risk factors. In eight out of the nine cases from 2004, the homicide appeared both predictable and preventable. In seven out of nine cases, at least seven or more risk factors were clearly identifiable in the history of the family circumstances. For the two years combined, 12 out of 20 cases (60%) had at least seven or more known DV risk factors associated with lethal violence. A proper risk assessment had been done in only one 2004 case, but unfortunately this assessment did not lead to a coordinated safety plan and risk management strategy.

e. DVDRC Subcommittee on Risk Assessment

As a result of the case reviews this year, the subcommittee observed that there is a lack of coordination and follow up of domestic violence cases, and a lack of continuing vigilance—particularly in the justice system—pending completion of the case. When serious injury or death occurs, the unacceptable but common response is that the case fell through the cracks. Unfortunately, a number of the tragic cases that result in fatalities occur when the perpetrator is subject to a bail order or the victim has obtained a restraining order. As a result, the focus of attention of the subcommittee this year has been on the need for a process to provide some measure of safety to victims, a process that would help limit the risk. This section of the report describes a basic case management framework, and provides a preliminary examination of a number of

different approaches that have been used by various communities in an effort to manage high-risk cases.

f. Government Announcements and Initiatives

Unlike inquest recommendations that deal with the individual circumstances of a person's death and the advancement of public safety, there is no follow-up process to ascertain specific responses to the recommendations contained in the DVDRC report. However, it is noteworthy that subsequent to the release of our first report, in 2004 the Ontario government announced a $66 million Domestic Violence Action Plan to address domestic violence. The stated objective of the program is to enhance existing domestic violence programs and services and to implement new initiatives by placing a new emphasis on prevention and community support for abused women and their children.

The government announced that one goal of the program was to identify women and children at risk earlier in the process, and to that end $5.9 million would be spent on training, research, and conferences. Professional and service providers would be trained to intervene early and offer appropriate response, information, and supports. Further, training materials were to be developed to help front-line workers, professionals, family, friends, and neighbours detect early signs of abuse. In addition, $4.9 million was to be made available for a four-year public education and prevention campaign to help communities play an active role in ending violence against women and girls.

Another declared goal was to strengthen the justice response to domestic violence by:

- evaluating the domestic violence courts and bail safety programs;
- improving civil protections for abused women by improving enforcement of restraining orders and breaches; and
- improving communications between family and criminal courts.

To this end, the *Ontario Domestic Assault Risk Assessment* (ODARA) instrument will be tested in two jurisdictions in the province.

Many of the DVDRC recommendations in this report speak to the need to implement the announced initiatives, and it will be for others to assess the commitment of those in a position responsible to do so.

g. Review and Report Limitations

The individual case reports and data summary collection forms that form the basis of our case reviews and analysis have not been released to the public. All of the information obtained as a result of the coroner's investigation and provided to the Domestic Violence Death Review Committee has been subject to the confidentiality and privacy limitations imposed by the Coroners Act of Ontario and the Freedom of Information and Protection of Privacy Legislation. Unless and until an inquest is called with respect to the specific death, the confidentiality and privacy interests of the deceased, as well as those involved

in the circumstances of the death, still prevail. Accordingly, the individual reports, as well as the review meetings, remain private and protected. Each member of the committee has entered into and is bound by the terms of a confidentiality agreement that recognizes these interests and limitations.

The DVDRC's terms of reference direct that the committee, through its chair, report on an annual basis to the Chief Coroner the trends, risk factors, and patterns identified as a result of its review, and make appropriate recommendations to prevent deaths in similar circumstances. The recommendations in this report, while generalized, result from the review of the facts of the specific cases before the Domestic Violence Death Review Committee. Each reviewed case resulted in recommendations specific to that case, which were then distilled for the purpose of this report. This report's recommendations, as with the last report, may not be seen by some to cover as broad a spectrum of issues as those produced as a result of the domestic violence inquests and the report of the Joint Committee on Domestic Violence[5]. However, the more narrow focus of this report's recommendations should not be seen in any way to diminish or detract from the importance of the earlier recommendations of those other processes. Indeed, this report's recommendations and any future reports of the committee should be seen as supplementary to them.

The cases summaries in Chapter 2 are provided only to give the reader a general sense of the circumstances that led to the fatalities and issues that assisted the committee in formulating recommendations. They do not represent all the detail available or all of the issues necessarily observed by the DVDRC during the reviews. Further, the following caveat forms part of each case review and applies to this report as well:

> This document was produced by the DVDRC for the sole purpose of a Coroner's investigation pursuant to section 15 (4) of the Coroner's Act, R.S.O. 1990 Chapter c. 37, as amended. The opinions expressed do not necessarily take into account all of the facts and circumstances surrounding the death. The final conclusion of the investigation may differ significantly from the opinions expressed herein.

[5] *Working Towards a Seamless Community and Justice Response to Domestic Violence: A Five Year Plan for Ontario, A report to the Attorney General of Ontario by the Joint Committee on Domestic Violence*, August 1999.

Chapter 2 – Case Review Summaries

Case #1: OCC 4477/02

This case of homicide occurred in the spring of 2002. The deceased male victim, age 48, and the female perpetrator, age 34, had been living in a common-law relationship for approximately four years prior to the homicide. They lived in a small northern Ontario community in a three-bedroom trailer. They had one child together, however the Children's Aid Society had removed the child from their home the previous fall. They had other children from previous relationships, however they were estranged. The male victim was employed as a truck driver and he also worked as a self-employed mechanic. The female perpetrator was unemployed and had been unable to hold any employment due to her alcohol problems. She had been in various treatment programs over the years, and she had attempted suicide on several occasions. The weekend of the homicide, they had been together redecorating their trailer in the apparent hope of regaining custody of their child. She stabbed him to death at their residence sometime during the weekend of heavy drinking.

The couple shared a very violent relationship and both had a long history of alcohol abuse. They were both well known within their community and to the local authorities for their violent behaviour toward one another. She had frequent contact with the local women's shelter, however she was volatile and threatening and she terrified other community members. Both spouses had been subject to charges of assault and other violent offences toward one another. The perpetrator in particular had a long history of violence. She had been arrested 22 times for offences involving domestic violence, often using weapons such as knives, hammers, and broken beer bottles. In an earlier relationship, she had stabbed her then-boyfriend. With respect to the victim in this case, she had stabbed him on two prior occasions. The charge was withdrawn in the first instance because the victim refused to cooperate with the prosecution, and the second was still outstanding at the time of his death. Due to their violent relationship, some in the community openly speculated about which one would kill the other first.

The victim had as violent a past as did the perpetrator. He was known to have a violent temper. Approximately ten days before the homicide, he had been involved in an altercation with one of his spouse's uncles that resulted in her uncle being hospitalized and the victim being charged. At the time of his death, both the victim and perpetrator were facing criminal charges of violence and were on bail. She was on a recognizance of bail with respect to the alleged earlier stabbing of the victim, but without a term of non-contact with the victim. He was on bail for the offence against her uncle. Both were enrolled in a domestic violence counselling program, but they had only attended a couple of times.

On the day of the homicide, the perpetrator argued with the victim. No one else was present in the home. As the argument escalated, the perpetrator stabbed the victim in the

upper chest with a sharp knife or similar object, cutting deeply into his chest. Due to the nature of the wound, he bled to death within minutes. She covered his body with blankets where he lay on the kitchen floor, and she then continued to drink to excess and consume prescription medication. She was charged with second-degree murder. She subsequently pled guilty to the offence of manslaughter, and in addition to one and a half years of pre-trial detention, she was sentenced to a further eight years.

Case #2: OCC 13928-02

This case involves the homicide of a woman by her husband. The victim and perpetrator had been married for approximately ten years. They had two children together. The victim was well educated and had become very successful in her position with a large international corporation. Her husband, on the other hand, had been unemployed for most of the marriage, and while he attempted to find jobs, he had been largely unsuccessful.

The victim and perpetrator's marriage began to deteriorate, and in the spring of 2002 they separated. He had unfounded suspicions that his wife was having an affair. At one point, Children's Aid Society was called because the children had been seen wandering around the neighbourhood and appeared to be un-kept and unsupervised. They were, at the time, in the perpetrator's care. Upon separation, the victim and children moved in with her father, and the perpetrator eventually moved in with his mother and sister. Initially he had remained in the matrimonial home, but he found it too expensive to manage.

Between the time of separation in the spring and the homicide in the fall of 2002, the perpetrator made several attempts to get back together with the victim. He made excuses to see her and sent her emails requesting that she and the children come home. She refused. They did agree between themselves as to the terms of custody and access to the children. However, during the fall of 2002, they began to have disputes over the division of assets. While the perpetrator had hired a lawyer, the victim did not feel she needed one. She continued to meet directly with her husband to try and resolve the disputes, notwithstanding having several people tell her that he had made threats against her life. His sister called the victim at one point and told her that he had said that he if he found her with someone, he would kill her. He told a counsellor he had been seeing that he was afraid he would snap and strangle her to death. The counsellor called her and warned her of the threat. When told of these threats, she did not convey any sense of concern.

The husband suffered from depression, and at the treatment centre where he was receiving additional counselling, he had completed workbook sketches showing him killing his wife. The workbook also contained written messages expressing thoughts of rage against her because of his belief that she would get everything and he would be left with nothing.

One Saturday, they had agreed to meet at her place of business to discuss the sale of the matrimonial home. She had told her father that she was going to work and planned to meet her husband to speak with him. The perpetrator had the children that weekend and

had left them in the care of his mother while he went to meet the victim. When he came home from the meeting, he went immediately to his room where he was later found to have attempted suicide. An ambulance was called and he was taken to hospital where his self-inflicted injuries were found to be non-life threatening. Later the next day, after the victim had failed to return to her father's home, a relative went to her office and found her dead. She had been stabbed multiple times in the front and back, and her throat was slashed. The perpetrator pled guilty to second-degree murder.

Case #3: OCC 3689–02

This case involves the killing of a two-year-old girl by her father during the course of an on-going dispute and separation from his spouse. At the time of the killing, he was on probation for an assault involving her mother and had a restraining order. The perpetrator and his wife had two daughters, the victim aged two and her sister aged four. Their marriage had been rocky from the beginning. Over time, the perpetrator became increasingly abusive and threatening toward his wife. He would physically block his wife's movements throughout the house and occasionally physically restrain her. He threatened that if she called the police, he would say that she hit him and that she too would be charged. She believed his threats and therefore did not involve police until the final assault against her, which led to him being charged and removed from the home by police. He was released on bail with a term of no contact. Even though he complained bitterly that the charge was unwarranted, within a few months he pled guilty and was placed on probation, but without any requirement for counselling.

Earlier, when the marriage had begun to fail, his wife had sought support and counselling from several organizations, including Catholic Family Services and a local women's centre. She encouraged her husband to go to counselling with her, but he refused to go. At the group counselling, she was able to assess her own situation to the degree that she knew the relationship was abusive and that her husband was controlling her and intimidating her. She took steps to contact a family law lawyer and began the process of separation. While in the process of separating, they continued to cohabit in the same residence, on the advice of their family lawyer. That situation continued until the assault reported to the police and he was removed from the home. At that point, the Children's Aid Society became involved with the family due to police notification of children in the home where there had been an investigation of domestic violence. Only the mother was interviewed. She was deemed to be a fit and loving mother, and as such no risk to her children. The father was not interviewed or assessed. The file was closed and no further action was taken.

Initially, custody and access to the children was arranged through an intermediary, however eventually that arrangement broke down because of his abusive behaviour. Supervised exchanges then took place through a family access centre. Even then, access centre staff documented that the perpetrator would act inappropriately during these exchanges. He would ask to see his wife, notwithstanding that he was not permitted to by the terms of probation and a restraining order. He would be seen peering into her car in

the parking lot. At one point, he refused to hand over the children because he believed he saw her with another man in her car. Further, he had been breaching his restraining order for several months. On the advise of her lawyer she reported the breaches, but no action was taken by the police. He was seen stalking her in parking lots and at the children's school. He would attend the school and remove the children without his wife's authorization. Eventually it came to the point where, with the consent of the school, arrangements were made to home-school the children.

On the last exchange, after the mother dropped off the children at an access centre, the perpetrator picked up his two daughters and drove to a neighbouring community where he made his way to a secluded rural area. He parked his vehicle on the side of the road and took his two-year-old daughter to a spot beneath a tree where he slashed her throat with a knife and left her there to die. She was found to have died of a combination of hypothermia and blood loss over several hours. After abandoning her, he made his way with his other daughter to visit an acquaintance. When asked, he told the acquaintance that the baby was ill and with her mother. Then he telephoned the access centre and informed the staff that he would be keeping the children overnight as his car had broken down and he was unable to return them. The staff of the access centre told him that the police would be notified if the children were not returned. The mother of the victim was at the centre to pick up her children when her estranged husband called to say he would not be returning them. The police were notified, but no action was taken at that time, notwithstanding an existing family court order confirming the terms of custody and access. The mother went home without her children. The next day, he left his surviving daughter on the road across the street from her grandparent's home. When he did not returned his other daughter, police were again notified. The following day the mother went to the police station and it then became a missing person investigation. The perpetrator later revealed the location of the little girl's body.

The perpetrator pled guilty to second-degree murder and was sentenced to life imprisonment with parole eligibility set at 18 years.

Case #4 OCC 8939/02

In this case, the father of a two-year-old boy killed him in the midst of an attempt to kill the child's mother. At the time of the attack, the perpetrator, age 36, was on a bail release for charges of assault and threatening to kill his spouse, age 39.

The couple had only been together for a few years. Initially they lived in Toronto, but after the birth of their son they moved to a small town outside of the greater Toronto area. The allegations of assault and threatening death incident involved the perpetrator claiming that his spouse had cheated on him with another man. While choking her, he was alleged to have stated, "If I catch you cheating on me I'll kill you and the other man." He had been abusive in the past, all stemming from jealousy, but these earlier incidents went unreported. In an earlier relationship with another woman, the perpetrator had been convicted of assaulting her with a weapon when she said she was leaving him.

He assaulted her repeatedly with a belt and told her that she could not hide from him, that he would find her. He spent four months in custody for that offence.

When the perpetrator was arrested for the assault and threatening death charges, his spouse asked her father to help him get out on bail so he would not lose his job and would be able to continue to support them. Her father had a criminal record, and he enlisted the help of another young woman in order to be approved as a surety. They lied, telling the court that he was her father and that he had sufficient assets to qualify. The court approved the two of them and released the perpetrator on bail with a number of conditions, two of which required that he not enter the home occupied by his spouse and child, and that he have no contact with them, except as permitted by a Family Court Order. Notwithstanding the court order, he constantly contacted his spouse. He would stalk her, later calling to tell her that he knew where she had gone and what she had done. When she told him that she had a copy of the release order and that he was breaching it, he told her he did not care what it said, that no court order would stop him. His spouse did not report the breaches, declaring later that she was "too scared of him to do anything."

The police who investigated the assault and threatening death charges referred the case to the local Children's Aid Society when they found an infant in the home. The CAS investigated the welfare of the child. On finding that the house was clean, the child well cared for by his mother, and the perpetrator was out of the house, the CAS concluded there was no immediate threat. Their file was closed.

On the day before he was to return to court to deal with the charges, he called his spouse several times to try to have her accept him back. She refused and told him that she was afraid for herself and her child because of his violent behaviour. She told him that he needed help. He demanded to know what she was going to testify to in court, and stated that he believed that she would try to get him into trouble because she was probably involved with another man. After she hung up the telephone on him, she prepared her son for bed. As she sat on the couch with the child while he drank from a baby bottle, the perpetrator let himself in the back door and attacked her with a hammer. He struck her in the mouth, knocking out several of her teeth. After she fended off another blow, he grabbed his son by the neck and began to strangle him. She tried to pull him away from the child, but being unable to, she ran from the house screaming for help. He carried his son into the kitchen where he stabbed him twenty times in the chest with a butcher knife. He left the child in a pool of blood on the kitchen floor, threw the knife into the sink, and fled the house. He was later arrested for first-degree murder of his child and the attempted murder of his spouse. He was found guilty of both offences and sentenced to life imprisonment.

The father of the spouse and the young woman he had enlisted to deceive the court in order for them to be approved as sureties for the release of the perpetrator were both found guilty of perjury and sentenced to periods of incarceration.

Case #5: OCC 4494-02

This is a case of homicide committed by a woman's estranged husband. At the time of the homicide, the perpetrator was on a bail release for the charges of assault and threatening to kill his spouse, with a term of no contact with her. His adult daughter and her husband were the named sureties and he was required to reside with them. He later killed his wife in circumstances similar to those that had resulted in the outstanding charges and bail release. Several weeks after his arrest and release, he followed his wife to a store. He waited in his motor vehicle in the parking lot for her to exit the store. When she did so, he forced her into the van and began to beat her with a wrench. She escaped from the van. As she ran through the parking lot, he ran her down with his van, killing her.

The victim had married the perpetrator at an early age; he was eight years older. They were married in January 1980, and he was violent with her from the beginning. In their first year of marriage, the victim left the perpetrator after he choked her. She fled to a shelter but he found her and took her home. Again, in 1984 he choked her to the point that she lost control of her bodily functions. These incidents went unreported. At the time of the homicide, the perpetrator was 52 years old and his wife 44. He had an elementary school education and worked as an unskilled labourer. He had a long history of marihuana and alcohol abuse. He had recently been prescribed sleeping pills and antidepressants. His family physician had given him a referral to a psychiatrist, but he had yet to be seen. Even his friends described him as being a bully, a jealous person and very controlling, especially around his wife. His children were fearful of him. In the past he had made threats to kill other family members because he believed they were stealing from his father.

The events that gave rise to the charges of assault and threatening death and his bail release occurred in early 2002. The perpetrator convinced the victim to go for a drive with him in the country. She had dyed her hair the previous day, and it was his belief that she had done so to attract other men. While he was driving, he punched the steering wheel and he threatened to strangle her. He stopped the vehicle and threatened her again. Believing that he was going to kill her, she fled from the vehicle. She ran to a nearby house where she was able to call police. After his arrest, the victim moved into a shelter, still fearing for her life. She later found a job, but the day before she was to have started it she was killed. She had purchased a cell phone and gave the number to her children. She started to receive telephone calls from the perpetrator while she was in the shelter. She reported these breaches of the bail order to the police. The police had planned to arrest the perpetrator for these breaches, however it did not occur before he killed her. Further, his daughter, concerned about his having made contact with her mother, also planned to revoke her surety for his bail release, however before she did he killed her mother.

The perpetrator was described as being very upset and depressed after he was charged. He was taken to a treatment centre for substance abuse and detoxification, but checked himself out within a few hours. In the days leading up to the homicide, the perpetrator drank heavily, increased smoking of marijuana, and complained to friends that his wife

only wanted his money. At one point he checked into a hotel and took an overdose of medication in an apparent attempt to kill himself, but a family member rescued him. At a bar the evening before he killed his wife, the perpetrator asked a friend he had been drinking with to play a song about suicide. Later, when he left the bar, he told his friend that he would not be seeing him again.

After he killed his wife, the perpetrator fled the jurisdiction, checked into a hotel, and again attempted suicide by drug overdose. He was discovered by police, arrested, and hospitalized. After recovery, he pled guilty to second-degree murder. He was sentenced to life imprisonment with parole eligibility set at 14 years.

Case #6: OCC 17760, 17761–03

This is a case of homicide–suicide. The victim and perpetrator had been married for 15 years and had one child, a daughter. The perpetrator was a police officer with 22 years experience. He had been known as a well organized, quiet spoken officer. He had been involved in an altercation while on duty several years earlier that had a significant impact on him, and he subsequently transferred to court officer duties. He had an obsessive-compulsive disorder and was very focused on finances and his pending retirement within the next several years. The victim, who had several jobs over their marriage, was on disability after sustaining a blood clot while working. The marriage had shown signs of failing, and the couple separated at one point in 1995. During this time, the couple attended marital counselling. Approximately three months later they resumed their marital relationship.

In December 2003, the victim advised her husband she wanted a divorce. According to friends, he told them he had no idea that such a thing would happen and he felt betrayed, hurt, and vulnerable. The victim had told him that she felt they were not compatible and that he was self-centred and controlling. She went to a lawyer and started divorce proceedings, which he was very upset about. He was quite concerned about the impact that the separation and divorce would have on his retirement and pension. They continued to reside in the same home. The perpetrator's lawyer advised him to go for mediation at family court. According to his friends, he pleaded with her to work out their problems and once again she agreed to go for counselling, but it failed. The victim became upset with him for mentioning the pending divorce at the counselling session in the presence of their daughter, contrary to his agreement not to tell her until after the holidays.

On the day before he killed his wife and himself, the perpetrator took his daughter to medical appointments and later made inquiries at work about health and dental benefits after the marriage break-up. When he returned home, he told his wife what her entitlements would be and then he left the house upset, returning later. The next morning, although off-duty, the perpetrator returned to the station and retrieved his firearm from his locker. He drove back home and went inside to the bedroom where he shot the victim, killing her, and then turned the gun on himself. Their daughter, who had been in her room

using her computer, heard the shots and ran to her parent's bedroom where she found her mother dead in bed and her father dead on the floor.

Case #7: OCC 2259-03

In this case, a husband, age 30, killed his wife, age 31, at a time when they had agreed to separate, yet were still living in the same residence. They had been married for almost five years, although it was described as being stormy throughout. There were no children from the relationship. They argued constantly about financial issues. While there were considerable verbal exchanges, there was no reported or known history of physical abuse in the relationship.

The husband worked as a truck driver and the wife started working in the business of promoting nightclubs. Her activity caused her to spend considerable time away from home at clubs and she became involved in the drug scene—both using and selling illicit drugs. She also started to engage in extra-martial affairs with other men. Family and friends, on the other hand, knew her husband as a quiet person who did not go to clubs and was not involved in the drug scene. He had no criminal record or prior police involvement.

Due to their differing lifestyles, they grew apart. They decided, after numerous arguments in the fall of 2002, to separate but agreed to continue living together in the matrimonial home and to share the responsibility of maintaining the residence while readying it for sale. During this time, the husband became reacquainted with a woman he had known from the time he was a teenager. They began to see each other, and the relationship developed to the point that he was spending some nights at her residence. They began to discuss marriage plans. Other nights he would sleep on a couch at his matrimonial home.

On the day before the wife was killed, she visited her mother, upset about money issues and the separation. She and her mother discussed how she could get a divorce and what would happen with the assets of the marriage. She returned home after meeting with her mother, stopping first to purchase cleaning supplies to work on the house. When she returned home, an argument with her husband developed over the sale of the house, division of the assets, and their finances. At some point, after speaking to a friend on the telephone, the wife went to bed and the husband retired to the couch for the night. According to an interview given to the police by the husband, admitting to killing his wife, he kept saying to himself in the morning, "why is she doing this to me?" He felt he "had no other option." He got a hammer, went into his wife's bedroom, and while she slept, struck her several times in the head, killing her. He left her body in the bed, left the house, and spent most of the next week at his girlfriend's residence. Immediately after the killing he took a number of steps to try to conceal his responsibility and construct an alibi.

The mother of the deceased became worried after not having heard from her for almost a week. The mother went to the house where she found her daughter dead in her bed. When

the police interviewed the husband, he confessed to killing his wife. He was charged with first-degree murder and later pled to second-degree murder and was sentenced to life imprisonment with parole eligibility set at ten years.

Case #8: OCC 6872, 9738–03

In this case, the perpetrator, age 25, shot the victim, age 23—his girlfriend and mother of his child—with a handgun, and then shot himself. Both died from a single gunshot to the head. They had an on and off relationship over a six year period, largely because of the perpetrator's extended periods of incarceration. He had an extensive record for crimes of violence and drug offences. He had been released on bail five days before the homicide–suicide. One veteran police officer described him as a "gun-toting drug dealer." The victim did not have any criminal history.

The perpetrator had been in custody for a drug-related offence. He had originally been detained, but after approximately eight months in custody, he was released on consent as a result of evidentiary problems. He was released on a substantial cash bail. His father was approved as surety, even though he had a criminal record. He was to reside with his father and not be away from that residence without being in the company of his father. He was also not to be in possession of any firearms. In addition to the term of this recognizance prohibiting his being in possession of a firearm, the perpetrator had a prior conviction for an unlawful use of a firearm—an occurrence involving the shooting of another victim left paralysed—that included a life-time prohibition as part of the sentence.

As a result of the abuse in her life and his most recent incarceration, the victim did not want to have any more contact with him. She feared for the safety of her child and herself. Shortly before his release, he told the victim that when he got out of jail he was going to kill five people. She believed that she would be one of those people, but made no report to the police at that time. Her sister's boyfriend reported that the perpetrator had threatened to kill the victim and her child, and that she was always afraid of him.

On the day that the perpetrator was released, notwithstanding the release order, the perpetrator's father—his surety—drove him to the victim's apartment. Her apartment was in a different city from that of the father, where the perpetrator was to reside. Upon his unexpected arrival, he declared his intention to reside there with her and the child. When he left to go to visit a friend, who the victim knew was holding the perpetrator's guns, she fled with her child to a friend's apartment. Two days later the victim phoned both the police and the local shelter to seek help in dealing with the perpetrator. No details were provided about the police call, and when queried, the police had no record of it. The only shelter record indicates she told them he had made threats, that he had just been released from jail, and that she wanted to get out of the apartment. She was told that the shelter was full and was given the phone numbers for other shelters in the city. Shelter staff also suggested that she call the Children's Aid Society for support and assistance. She found shelter at her sister's apartment.

The perpetrator found out where she was staying and called her repeatedly. The next day the perpetrator called the apartment and spoke to the victim, stating he wanted to visit his daughter. The victim tried to put him off with a number of excuses. She asked him to wait for her mother to be at the apartment at the end of her work day. He phoned back continuously via a cellular telephone. The victim told him that she was afraid to be alone with him, and considered ways to let him see the daughter without her being directly involved. Finally she told him that she would call him back in five minutes. She then called 911 and remained on the line. The perpetrator, speaking over his cellular phone, arrived at the apartment door just as two police officers, who had been dispatched, arrived at the building. Just after he gained entry to the apartment, while the victim was still speaking with the 911 operator, the police officers arrived outside the apartment door. On discovering the police were at the door, he said "I can't believe you called the police on me." He then produced a 9mm handgun. He shot the victim in the head in front of her daughter and sister, and then turned the gun on himself. The police had no chance to act to prevent the shooting.

Case # 9: OCC 4192-03

The victim and the perpetrator had known each other for several years. In this case, the perpetrator beat the victim to death in the hall of his rooming house after a day of heavy drinking. She would visit the accused for days at a time, largely for the purpose of drinking alcohol. During these drinking sessions, arguments would occur between the two that would result in the victim being physically abused by the perpetrator. Following these drinking bouts over the past three years, the victim was seen with various physical injuries ranging from blackened eyes, facial cuts, and a broken shoulder and wrist. Both the perpetrator and victim would say these injuries resulted from her falling and/or bumping into objects. The police and her family suspected abuse, but her refusal or inability to disclose due to her lack of memory inhibited intervention other than to administer to her injuries.

She had been married for 26 years to another man and was the mother of two boys. Her alcoholism led to her leaving her husband, although they remained in contact. He knew of her drinking habits and relationship with the accused, but did not want to divorce the victim because of financial factors. Over the years of her relationship with the perpetrator, various incidents of violence involving the victim occurred at or near his home. Many incidents went unreported to the police. On one occasion where she did complain to police, the charges were later withdrawn at her request and he entered into a peace bond for 12 months.

On the day of her death, the perpetrator, who was undressed from the waist down, was seen straddling the victim, who was also semi-clothed, banging her head repeatedly on the floor in the hallway of the rooming house. When police arrived, her naked body was found on the floor in the perpetrator's room. She had died of closed head injuries. He was convicted of manslaughter and sentenced to ten years in prison.

Chapter 3 – Summary of Data Analysis 2004

In 2004, the DVDRC reviewed nine domestic violence cases that involved homicides. There were 11 deaths, since two of the cases involved a homicide–suicide. Two of the cases involved homicides of toddlers by their fathers who were targeting their estranged spouse by killing their child. Both of these cases involved criminal and family court proceedings in which there were criminal charges and conflict over access to children.

Since the inception of the DVDRC in 2003, the committee has primarily reviewed cases cleared by the court in the previous year. In our first year of operation, we reviewed more homicide–suicides because there was no court involvement in these matters. In 2003, we reviewed cases principally from 2002. In 2004, we reviewed cases from 2003. These complex and time-consuming reviews have limited our ability to complete this process for every available case. As indicated in Table 1, the number of homicide cases per year between 2002 and 2004 has averaged 26 cases, with an average of 34 deaths. In reviewing nine cases, the DVDRC limited itself to a thorough analysis of slightly over one-third of the available cases for 2004. Over the past two years, approximately 40% of the available cases were reviewed.

For the cases reviewed in 2004, eight out of nine cases involved a male perpetrator and female adult victim who was the primary target of the domestic violence. The term primary target is used since the actual homicide victim was a child in two of the cases. In one case, access to the adult victim was limited by supervised exchanges for children, and in the other cases a court order forbade any contact. The overall data from Ontario domestic violence homicides, shown in Table 1, suggest that males as perpetrators and women as victims represent approximately 80% of the cases, a four-to-one ratio. This percentage and ratio is comparable to other DVDRC's findings in the U.S. and the national homicide data according to Statistics Canada.

Table 1 – Domestic Violence Homicides in Ontario 2002–2004

Year	Incidents	Deaths	Women	Children	Men	Details
2004	27	35	25	1 (F)	9	15 deaths homicide/suicide 1 attempted homicide/suicide 1 attempted homicide/homicide
2003	25	29	19		10	8 deaths homicide/suicide 5 attempted homicide/suicide
2002	26	40	21	4 (F) 1 (M)	14	15 deaths homicide/suicide 1 attempted homicide/suicide

The data presented for 2004 represent nine cases. The summary tables that follow provide an overview of these cases, as well as an accumulated picture from the totals of 2003 and 2004 (20 cases = 11 from 2003 + 9 from 2004). Table 2 provides an overview of victim and perpetrator background information. The majority of the cases involved Canadian citizens who were married couples with children. As mentioned above, eight of the nine cases involved male perpetrators. In the one case of a female perpetrator and male victim, there had been a previous history of his violence in the context of this intimate relationship, but no self-defence was raised in the criminal proceedings. Both for 2003 and 2004, background information suggests that the perpetrator most likely had a criminal record (ten out of 20 cases), had made previous threats/attempts at suicide (nine out of 15 cases), and had experienced significant life changes such as job loss (18 out of 19 cases).

Table 3 provides an overview of the nature of the cases. Two of the nine cases were homicide–suicides. Four out of the nine cases involved stabbing as the cause of death, which is comparable to 2003 data. Firearms were used in two out of nine cases in 2004 and six out of 20 cases (30%) for the two years combined. It may be interesting to note that in the U.S., over half of female domestic violence homicide victims (54%) are killed by firearms, compared to one in five killed by knives and other cutting instruments.[6]

Table 4 provides an overview of the common risk factors associated with the domestic violence literature and risk assessments. Table 4 highlights the most common factors found in the nine cases reviewed in 2004, as well as the overall common factors for 2003 and 2004 combined. The most consistent factors appear to be an actual or pending separation, prior history of domestic violence, and a perpetrator who had made threats to

[6] Violence Policy Centre (2004). *When Men Murder Women: An Analysis of 2002 Homicide Data*. Washington, DC: Author

harm himself or his partner in the past. A history of depression, alcohol abuse, and stalking behaviour appear to be present in at least half of the cases. Four of the nine cases in 2004 involved child custody and access disputes, in contrast to this issue not being identified in our 2003 reviews.

An important concern to the DVDRC is the extent to which the homicides reviewed appear predictable and preventable with the benefit of hindsight and the analysis of well-known risk factors. In eight out of nine cases, the homicide appeared both predictable and preventable. As an illustration of this fact, we reviewed the number of known risk factors in 2004 cases. These results are illustrated in Figure 1 and suggest that in seven out of nine cases reviewed in 2004, at least seven or more risk factors were clearly identifiable in the history of the family circumstances. For the two years combined, 12 out of 20 cases (60%) had at least seven or more known domestic risk factors associated with lethal violence. A proper risk assessment had been done in only one 2004 case, but unfortunately it did not lead to a coordinated safety plan and risk management strategy. [7]

[7] We acknowledge the assistance of Mr. George Goodall, a graduate student in the Library and Information Science program at the University of Western Ontario, in the development of the database and data analysis.

Table 2 – Victim and Perpetrator Information

NOTE: The information reported is only relevant to the perpetrator and domestic partner (i.e., if the victim of homicide was a child, his/her information is **not** reported).

Variable	2004		2003–2004 Combined	
	Victim Information	Perpetrator Information	Victim Information	Perpetrator Information
Gender	89% female 11% male (n = 9)	11% female 89% male (n = 9)	95% female 5% male (n = 20)	10% female 90% male (n = 20)
Age when incident occurred (years; adults only)	Min = 22 Max = 48 Median = 39 (n = 9)	Min = 24 Max = 65 Median = 39 (n = 8)	Min = 19 Max = 81 Median = 39 (n = 20)	Min = 20 Max = 89 Median = 43 (n = 19)
Type of relationship between victim and perpetrator	Legal spouse — 66% Common-law partner — 11% Other — 22% (former partner/current friend) (n = 9)		Legal spouse — 50% Common-law partner — 15% Estranged boyfriend/girlfriend– 10% Boyfriend/girlfriend — 5% Divorced — 5% Estranged legal spouse — 5% Other — 5% (former partner/current friend) Same-sex partner — 5% (n = 20)	
Length of relationship (adults only)	< 1 year 0% 1–10 years 78% 11–20 years 11% 20–30 years 1% (n =9)		< 1 year 5% 1–10 years 55% 11–20 years 10% 20–30 years 30% (n =20)	
Children in common (adults only)	0 22% 1–2 66% 3+ 11% (n = 9)		0 30% 1–2 45% 3+ 25% (n = 20)	
Residency status (adults only)	Canadian citizen — 100% (n = 9)	Canadian citizen — 100% (n = 9)	American citizen — 0% Canadian citizen — 84% Immigrant/ Refugee —16% (n = 19)	American citizen — 5% Canadian citizen — 80% Immigrant/ Refugee —15% (n = 20)

Employment status (adults only)	Disability — 0% Employed part-time — 29% Employed full-time — 43% Retired — 0% Unemployed — 29% Welfare — 0% (n = 9)	Disability — 12% Employed part-time — 0% Employed full-time — 50% Retired — 0% Unemployed — 25% Welfare —13% (n = 8)	Disability — 6% Employed part-time — 29% Employed full-time — 41% Retired — 6% Unemployed — 18% Welfare — 0% (n = 17)	Disability — 5% Employed part-time — 0% Employed full-time — 58% Retired — 5% Unemployed — 26% Welfare — 5% (n = 19)
Criminal history (adults only)	Yes 14% (n =9)	Yes 56% (n = 9)	Yes 12% (n = 20)	Yes 50% (n = 20)
Prior counselling (adults only)	Yes 50% (n = 8)	Yes 33% (n = 6)	Yes 27% (n = 18)	Yes 44% (n = 16)
Threats or attempted suicide (adults only)	Yes 0% (n = 8)	Yes 83% (n = 6)	Yes 0% (n = 18)	Yes 60% (n = 15)
Significant life changes (adults only)	Yes 78% (n = 9)	Yes 89% (n = 9)	Yes 81% (n = 19)	Yes 94% (n = 20)

Table 3 – Homicide Information

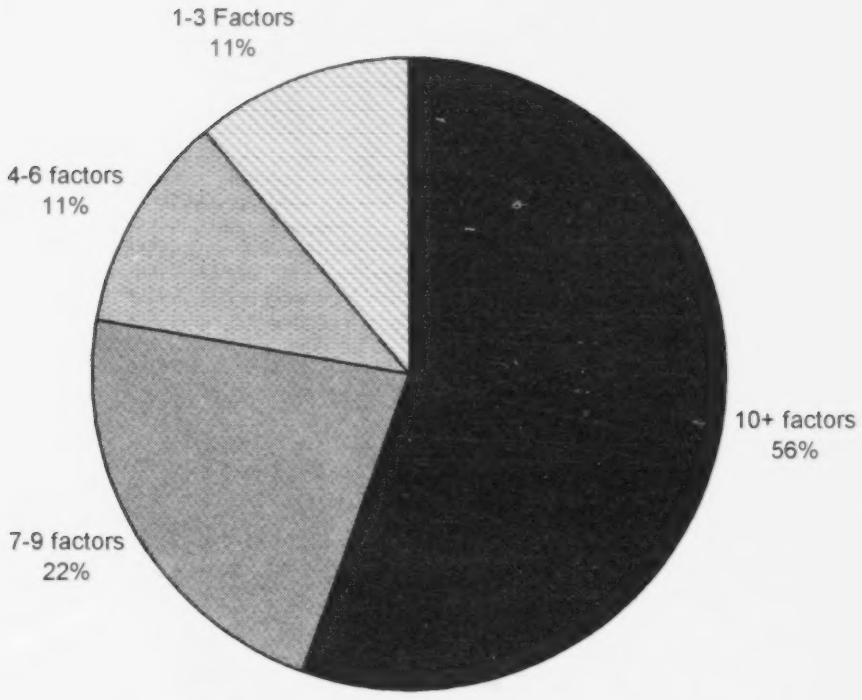
	2004	2003-2004
Type	Homicide 77% Homicide–suicide 22% (n = 9)	Homicide 45% Homicide–suicide 45% Multiple homicide–suicide 5% Multiple homicide 5% (n = 20)
Cause of death	Stabbing 44% Gunshot 22% Beating 22% Other 11% (Beating and hit by vehicle) (n = 9)	Stabbing 40% Gunshot 30% Beating 15% Strangulation 5% Poisoning 5% Other 5% (Beating and hit by vehicle) (n = 20)

Table 4 – Common Risk Factors from DVDRC Analysis

Risk Factor	2003		2003–2004	
	n (n=9)	Percentage	n (n=20)	Percentage
Actual or pending separation	7	78%	16	80%
Other factors that increased risk	7*	78%*	10	50%
Prior history of domestic violence	7	78%	12	60%
Escalation of violence	6	67%	10	50%
Prior threats to kill victim or threats with a weapon	6	67%	9	45%
Obsessive behaviour (including stalking the victim)	6	67%	11	55%
Depression (or other mental health or psychiatric problems)	6	67%	13	65%
Perpetrator unemployed	5	56%		
Excessive alcohol and/or drug use	5	56%	10	50%
Child custody or access dispute	4	44%	4	20%
Control of most or all of victim's daily activities	4	44%	9	45%
Extreme minimization or denial of spousal assault history	4	44%	4	20%

* Comments on "other factors" include: health conditions, perpetrators isolation, lack of risk management by professionals, lack of risk assessment or safety plan; breaching court orders, requested stress leave due to depression, statements to co-workers about intentions, gambling addiction; perpetrator was isolated from his friends and family; violence with others; domestic violence with former partners; chronic and severe substance abuse including prescription drugs and non-prescription drugs and alcohol; level of physical violence is above "common assault" and involves weapons of opportunity; events of violence involved little precipitating factors; both victim and perpetrator were living with a relationship of violence; emotional abuse, distress over disruption of retirement plans, and financial issues caused by pending divorce; perpetrator has relationship with new partner; financial factors; continued co-habitation after intention for separation.

Figure 1 – Number of Risk Factors Identified in Cases Reviewed (2004)



Chapter 4 – Recommendations

a. Awareness and Education

In the case reviews of domestic violence deaths in the year 2002, we looked at three major subject areas of potential intervention. One of the subject areas addressed increasing awareness of and education about domestic violence. In every case that was examined, family members, friends, neighbours, and/or professionals had some knowledge of the escalating circumstances between the perpetrators and victims. Some did not recognize the warning signs, nor did they act upon them. Many of 2002–2004 cases showed the continuing need to target culturally competent public awareness and education.

It has been proven that community alliances are critical to optimal success. In many communities, support for awareness and education on domestic violence initiatives has been received from community-based violence against women (VAW) services, police, victim services, family and children counselling services, and the private sector working together as a team.

1. **There is a continuing need to better educate both the public and professionals who come into contact with victims and perpetrators of domestic violence about the dynamics of domestic violence and the need to take appropriate action with potential abusers, victims, and their children. In particular, this education has to include an awareness of the risk factors for potential lethality.**

There appears to be increasing public awareness of and professional training about domestic violence. However, the cases we reviewed this year highlight the need to expand this awareness and make the links to appropriate action. In many of the cases we reviewed, the indicators for domestic violence were present and even recognized, but there seemed to be a lack of any referrals and/or interventions focussing on safety for victims and treatment for perpetrators. In short, people know how to recognize the occurrence of domestic violence but do not know what to do upon this discovery. Public awareness campaigns need to emphasize steps that may be taken such as where/who to call (Assaulted Women's Helpline—a Provincial crisis line available 24 hours a day, seven days a week—or distress centres) when they think there may be a domestic-related crisis brewing. Ideally, the process of raising awareness should be embedded in the public education system so students learn about these issues early in their lives before their transition to adulthood.

In most cases we reviewed, there were at least seven or more risk factors associated with potentially lethal violence. It is important to understand that domestic violence occurs along a continuum. This continuum includes minor and isolated incidents, progressing to an overall pattern of behaviour over time within the relationship. This overall pattern of

behaviour suggests a high likelihood of repeat violence, dangerous behaviour, and even the potential for life-threatening harm. Throughout our case reviews, we again found multiple opportunities for intervention by friends and family, by front-line professionals such as family doctors, and by more specialized domestic violence services such as police and shelters for abused women. When properly done, risk assessments offer a number of benefits to the victims, as well as inform victims of the potential danger they are in. The assessment process also gives the assessor an opportunity to provide victims with direct services or referrals to services available that promote safety and help reduce the risk.

Victims of domestic violence need information about risk factors for lethality and what to do about them. In one case of attempted homicide–suicide, the surviving victim suggested that she and other victims needed to have more information about what kind of the services are available; she had no idea what was available. In another case, the surviving spouse of an attempted homicide–suicide seemed totally overwhelmed and felt like she was basically on her own due to her lack of knowledge and trust in the system. She advised that the perpetrator had caused such fear in her life that, even after he was gone, she still felt his controlling influence. These cases also help illustrate that waiting for decisions by the justice system, whether during family, criminal, or child protection proceedings, can leave some victims vulnerable, unprotected, and without support throughout the process due to lack of information about how to access services.

In a number of cases, we observed that professionals might have in fact minimized the danger victims were in because they focused exclusively on other factors, such as mental health and alcoholism issues involving the victims and perpetrators. Problems in other areas of adjustment may escalate the risk offenders present and magnify the vulnerability of individual victims.

Individuals in the workplace have a unique opportunity to observe the impact of domestic violence on victims, or to observe the perpetrator's disconcerting behaviour. Both employers and co-workers have a potential role and responsibility to provide support and either seek out or help activate appropriate community interventions. In the same manner in which a workplace culture can foster caring through resources such as employee assistance programs that tend to focus on mental health and alcohol-related problems, domestic violence needs to be recognized as a significant issue requiring intervention.

In one of our cases, there were many warning signs of an employee's escalating distress in the context of a known prior mental health diagnosis that might have led co-workers and supervisors to intervene. In response to high-risk cases, friends, neighbours, family, and co-workers have an essential role to play as part of a wider community coordinated response. We do not intend to place an extraordinary responsibility on individual citizens, but hope that an enhanced awareness on the part of the public will be joined by a growing sensitivity on the part of professionals and community agencies in activating an appropriate response to the domestic violence in the lives of their family members, friends, neighbours, fellow co-workers, and employees.

All public education recommendations include the fact that any domestic violence training must be done within an integrated anti-oppression framework, which is inclusive of race, class, ability, sexual orientation, age, and religion.

2. **It is recommended that child welfare and protection agencies receive ongoing training to recognize the risk factors for domestic violence. Furthermore, this training should address effective interventions that promote the safety of mothers and children.**

3. **It is recommended that child welfare and protection agencies address the following issues:**

   - All child welfare organizations should follow the provincial policy currently in place, known as the *CAS VAW Collaboration Agreement*. This policy informs how both the violence against women and child welfare sectors must work together in situations where there is violence against women. It also ensures that perpetrators are held accountable to the fullest extent possible within the parameters of each sector's mandate.
   - Specialized training and education should be provided for all child welfare staff on the most effective ways to intervene in domestic violence cases. Currently, assessment focuses primarily on the mother's ability to protect her children. There is minimal focus, if any, on intervening directly with the offender on risk reduction and containment, and assessing if access should be permitted, particularly if the abuser remains untreated.
   - Present assessment reports that address a comprehensive analysis of domestic violence issues, including the risk factors for potential lethality, should be provided to Family Court judges so they have the necessary information prior to making decisions regarding custody and access to children.
   - It is suggested that there be a quality assurance component built in to the child welfare sector to ensure that best practices and standards of care for interventions are maintained.
   - Child welfare workers need to have the opportunity to increase their skill and comfort level in acting to locate, interview, and assess abusers to safely intervene in ways that enhance the safety of mothers and children and to hold abusers accountable.
   - Child welfare workers need to have the opportunity to increase their skill and comfort level in interviewing women at risk and how to connect them to support systems in the community to enhance the safety of mothers and children.

In all the cases we reviewed involving children, the child welfare sector was involved and had a key role to play in assessing risk to mothers and their children. Opportunities existed to provide safety planning for both mothers and their children, make referrals to

supportive violence against women services (VAW), help decrease their isolation, and respond to their ongoing need for assistance and protection, particularly when faced with custody and access issues. As a result of its role and mandate, the child welfare and protection sector is in a unique position to assess the dangerousness of the abuser. In addition, this sector can also make recommendations to the court systems regarding decisions related to access to children and appropriate interventions with the abuser related to risk management, parenting capacity, and accountability.

In the cases involving children, a number of risk factors associated with the perpetrators were clearly present, including histories of past violence, criminal convictions accompanied with numerous breaches of court orders, addictions, separation, custody and access disputes, and ongoing harassment and stalking of mothers and their children. In two tragic cases where young children were killed, no attempt was made to assess the potential lethality risk of untreated abusers fighting for access to their children as a way of continuing to exert control over the mothers of the children. Without the appropriate assessment and characterization of the perpetrator's behaviour, the mothers and their children were exposed to the risk of escalating violence and ultimately the deaths of the children. The murders of the children were a way for the perpetrator to punish the mothers. In one case where child welfare was involved, we heard that the abused mother was reluctant to reveal her fears to the CAS due to her belief that they would remove her child from her care. In another case, the mother did not see the child welfare worker as a potential ally in seeking safety and assistance. In a candid revelation to the committee, she felt the worker was only interested in the state of cleanliness of her home.[8]

4. It is recommended that lawyers in family law practice receive continuing education on understanding and recognizing the dynamics of domestic violence and the risk factors for lethality associated with separation, divorce, and custody and access.

Family law lawyers are well placed to recognize domestic violence and the escalating risks in a couple's separation. In our review of cases in the past two years, separation and a prior history of domestic violence are significant risk factors for women and children facing death at the hands of the intimate partner. Lawyers often see victims and perpetrators in crisis, and have a unique opportunity to intervene to make appropriate referrals and develop plans to enhance safety where there is conflict over child custody, support, and possession of the matrimonial property. This type of representation is among the most important that a lawyer can provide: it can save lives.

There is no family law case more complicated than a case in which safety issues are present and the abuser uses the legal system to continue to harm and harass. These cases are both challenging and time-consuming. Family law lawyers would benefit from the opportunity to receive specialized training in the dynamics of domestic violence and assistance in identifying risk indicators that might lead to lethal violence. This specialized

[8] See also recommendations no. 23 to 26 below regarding child-related issues and domestic violence.

knowledge would guide them in seeking appropriate assessments. Trying to have clients benefit from community counselling programs and promoting safe access through supervised visitation programs are essential strategies. We reviewed two cases where toddlers were killed in an apparent attempt to punish the victim for leaving an abusive relationship. In retrospect, more information should have been available to the court to help identify the level of risk that these toddlers and their mothers faced. In one case, advice was given—as it often is—that the victim should remain in possession of the home to protect property rights prior to actual separation. However, there was no clear understanding of the risk factors present. If these factors had been recognized, it might have resulted in a different course of action and outcome.[9]

5. **It is recommended that there be ongoing training for police on the appropriate response to domestic violence cases that involve child custody and access, which may be a time of high risk requiring special vigilance. These cases require the development of a high-risk case management protocol specific to domestic violence cases. Such a protocol needs to be accompanied by appropriate training focused on addressing the dual goals of victim safety (intervention) and offender risk reduction/containment (case management).**

The criminal justice system is concerned with the safety of the alleged victim in cases of domestic violence. We have seen that when there is a combination of actual or pending separation, child custody disputes, and a prior history of domestic violence, it can be a dangerous time requiring special vigilance by the police. In one of our case reviews, a perpetrator with a prior history of violence and breaching court orders did not return the child to a supervised access centre at the specified time. At the time, the police did not perceive it to be a high-risk situation, and no immediate action was taken. The perpetrator murdered the child.

When responding to domestic violence calls, it is critical for police to be aware of the indicators of dangerousness. Police training should include an understanding that domestic violence is a process and not a single event. Accordingly, when high-risk indicators are present, a case management protocol needs to be put into effect to ensure there is ongoing monitoring and supervision. Breaches of bail need to be dealt with swiftly. As discussed in our risk assessment subcommittee section, optimally a case manager should be responsible for the safety of the victim by receiving ongoing information about the behaviour of the accused while on bail. Police should also receive training on understanding family law restraining orders and their enforcement.

6. **It is recommended that awareness and education programs address the *culture of silence* surrounding domestic violence and its apparent acceptance that still exists in some families and small communities.**

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[9] For more information on best practice guidelines for family law lawyers, see *The Centre of The Storm Durham Speaks Out: A Community Response to Custody and Access Issues Affecting Woman Abuse Survivors and Their Children*, www.womanabuseprevention.com

The committee has reviewed a number of cases where family or members of small communities were well aware of threatening or abusive conduct, but failed to act upon it in an effective way. In one instance, members of the community were said to be figuratively wagering on which of the partners in the relationship would kill the other first. The committee considered a number of possible reasons for this reluctance to act, including: fear of the perpetrator; social or familial consequences in getting involved; cultural barriers (e.g., being ostracized from their families and community); inability to recognize the conduct as a serious indicator of risk for escalating violence; and the fact that some victims minimized the conduct and did not want third parties involved. Whatever the basis, this culture of silence is a barrier to violence being reported, the victim getting necessary help, and the creation of a safer environment for all parties. Unfortunately, in some respects, it harkens back to another time when domestic violence was considered a private matter.

7. **It is recommended that all healthcare providers be taught to be mindful of the dynamics of domestic violence and the potential for lethality, especially when working with patients who have a history of alcohol and/or drug abuse, depression, anxiety, or suicidal ideation. When domestic violence is identified in the patient's life, the potential for lethality should be assessed by the healthcare provider, or the patient should be referred to others with an expertise in making such assessments.**

In three of the cases, the perpetrators were seen by their physicians or another counsellor for mental health concerns, but there was no evidence or documentation of risk assessments having been done. Subsequently, these perpetrators went on to commit homicide. Consideration should be give to including education about the dynamics of domestic violence and the potential for lethality and its assessment in the undergraduate and postgraduate curricula for medical students and students of other healthcare professions. Similar information could also be incorporated into continuing medical education and professional development for other healthcare professionals.

8. **It is recommended that front line service providers (police, shelter workers, paramedics, medical staff) receive training in recognizing that the effects of drug and/or alcohol addictions on the victim can sometimes cloud the assessment of underlying domestic abuse.**

In two of the cases reviewed by the committee, the victim's and perpetrator's alcoholism presented a barrier to their ability to access services. The service providers had difficulty recognizing that domestic violence was occurring. As a result, the professionals the victims and perpetrators came into contact with missed opportunities for intervention in both cases. In one case, repeated physical injuries to the eventual homicide victim were written off as having occurred as a result of alcoholism and not as a result of domestic violence since the victim did not complain about the perpetrator.

9. Persons working in occupations with access to firearms, such as police, may experience barriers in the workplace to the disclosure of mental health and emotional problems. It is recommended that a change in the organizational culture be initiated to establish a climate conducive to such disclosure, without fear of recrimination or employment restrictions.

Police service managers, supervisors, and police officers should receive training to recognize the link between the potential for self harm and harm to others associated with access to firearms. This is especially true when an officer experiences significant job-related and life stressors. Further, once it is recognized that an officer is in a potentially vulnerable position, the organization should ensure the officer is treated respectfully and in a non-discriminatory way to enable him or her to continue to be a productive and valuable employee. The fear of job loss or recrimination from the reporting or acknowledgment of personal strife has to be eliminated for it to be disclosed and acted on appropriately.

10. It is recommended that where feasible and practical, police services should give consideration to supervised control of issue firearms when officers are off duty.

Supervised control of issue firearms includes but should not be limited to having the officer complete a sign-out sheet identifying the reason the firearm is being removed from its secure location, and a record of the supervisor's approval of its removal. An example would include when an officer requires his or her firearm for a non-scheduled task (e.g., off-duty training and firearm practice). It is acknowledged that it would be impractical to require all police officers, depending on their duty assignments, to lodge their issue firearms in a supervised control access location, however this should be considered the exception rather than the rule.

In one case reviewed by the committee, a police officer who was required to lodge his firearm in his locker at his police division retrieved it, along with ammunition, without explanation when off-duty. He used it shortly afterwards to kill his wife and himself.

11. It is recommended that the Ontario Court of Justice consider using high-risk cases where judicial interim releases occurred, as reviewed by the DVDRC, as case scenarios as part of the ongoing educational programs for Justices of the Peace who conduct the majority of bail hearings in the province.

The committee has examined several tragic cases involving perpetrators with a number of pre-existing risk factors who had been released on bail and who subsequently killed their spouse or child. In the circumstances of court proceedings, unless there is an appeal or review and superior court direction, the opportunity to benefit from post-event analysis is lost. There are no appeals from these cases. The lessons that these cases can offer must not be lost. It is common practice for physicians and others to re-examine their cases to learn whether improvements can be made in how the case was treated. While every case will be determined on the evidence and the circumstances particular to it, these are the

kind of cases that should be used by all involved to ascertain the lessons they may learn to help avoid future tragedies.

b. Assessment and Intervention

12. The Committee recommends that healthcare providers use risk assessment tools to assess the potential for domestic violence/abuse, suicide, and/or homicide.

As the concept of risk assessment becomes better understood, it is important for community professionals to recognize that these assessments are not limited to use by professionals involved in the justice system. Every sector, including the healthcare sector, needs to use these tools when clients reveal domestic violence in their lives. Healthcare providers in hospital and community settings are well placed to gather critical information after victims or perpetrators present physical injuries or mental distress as symptoms. The nature and history of domestic violence, as well as precipitating crises such as separation and custody disputes, need to be thoroughly explored. Without a risk assessment framework, information gathered might not be seen in the serious light in which it should be understood.

In one particular homicide–suicide case, the perpetrator was given a series of tests by a physician/psychotherapist to take home to complete. It was not until after the homicide–suicide that police obtained the results as part of the coroner's investigation. As a matter of practice, the committee recommends that when such tests and risk assessment tools are used, they should be administered and completed in the presence of the healthcare provider.

13. It is recommended that intake workers at women's shelters use standardized risk assessment tools to thoroughly assess and manage the potential risk of the woman seeking assistance. Current existing risk assessment tools should be tailored to meet the needs of community-based violence against women services and the women they serve. Further, all workers should receive training on the use of such standardized risk assessment tools.

14. It is recommended that, in any community where there are a number of shelters available to assist victims of domestic violence, a central registry of available beds for victims, as well as a means of transportation to the available facility, be established.

15. It is recommended that shelters be supported to create ways to effectively coordinate services and referrals to minimize the need for a woman seeking shelter to navigate the system on her own, and to maximize the ways shelters

can work together to provide a seamless and supportive response to the woman and her children.

A woman in need of assistance and protection should only have to make one call to access the shelter system. Shelters provide key services in response to women and children seeking safety from abusers. In one of the cases reviewed, the victim who disclosed indictors of high risk—including death threats, the abuser having been recently released from jail, and threats to take her child—sought assistance from a shelter and was advised space was not available. She was directed to contact other shelters. It was also suggested that she contact other services on her own. She was advised that if she had concerns for her child's safety, she should contact the local Children's Aid Society. It was reported that she declined out of fear that CAS might remove her child. In another case, a shelter assessed a victim as being in a low to moderate risk situation without supporting documentation. It would be helpful to have a standardized province-wide risk assessment process for shelter intake.

In another complex situation that involved a number of barriers—including geographic isolation, cultural factors, addictions, and absence of batterer intervention programs—a woman, who was both a victim and herself a perpetrator of violence, sought and received her greatest support from the local shelter even though the workers were fearful of her. In this case, it was said that members of the community expected one of the partners to eventually kill the other as a result of their continuous history of significant violence toward one another. Given the trust the woman held for them, the shelter appeared to have been in the best position to manage the case and take the lead in a case conference to implement an effective community response. However, the shelter lacked the proper resources or other local services to do so. A local case coordination of services and support process might have made the necessary difference to avoid the anticipated death of one of the partners in this case.

While police are currently completing *Domestic Violence Supplementary Reports* in an attempt to gather information and identify situations where the likelihood of further violence is of concern, it would appear that very little is being done to clearly identify high-risk cases that require additional monitoring. The police are obliged to record answers to questions in the *DVSR*, but there is no specific analysis of what the answers mean and what qualifies as a high-risk case. Our committee has recommended that specific information on lethality be gathered using a form such as the *Domestic History* form. This form captures the victim's detailed responses to specific questions. The information gathered can then be used at a bail hearing, and can be used to source other risk assessment tools. A tool such as *ODARA* may help to determine whether another assault may occur. A tool like J. Campbell's *Danger Assessment* may help identify potential lethality.

A number of cases reviewed over the past year were involved in the criminal justice system. Some of these cases involved accused persons who had been released on bail with conditions. It would appear that none of these cases were red-flagged for immediate intervention and management. As the case was never identified as a high-risk case, and

even though there were ongoing breaches of bail and an escalation of dangerous behaviours, no monitoring or management of the case took place. A proper risk assessment is necessary to identify a high-risk case. Once identified, it should trigger a high-risk case management response. The risk assessment process also has a number of benefits to victims. One benefit is that victims will be informed about the potential danger they may be in. Another benefit is that victims can then be made aware of a number of appropriate services available to assist them.

16. **It is recommended that police put processes into practice to identify, monitor, and manage high-risk cases, and to vigorously enforce bail conditions arising from a violent offence or threat of violence. Further, it is recommended that police services institute a dedicated police unit that has links to community-based experts to deal specifically with high-risk domestic violence cases, to ensure an appropriate case management response in such cases.**

Several reviewed cases involving the criminal justice system were not identified as high-risk cases and no high-risk monitoring or management ever took place. In some of these cases, police services had the grounds to arrest an offender for breach of conditions but failed to do so at the first opportunity. Instead, they chose to allow the offender to voluntarily turn himself in to police. During the resulting delay, the offender demonstrated lethality.

Where the offender is living outside the jurisdiction where the precipitating offence took place, the original investigating police service must ensure that the police service in the jurisdiction where the offender is living is advised of the circumstances of the case, conditions of bail, and degree of risk. A high-risk case management unit will ensure this is done expeditiously. In this way, there can be oversight and continuity with respect to the ongoing monitoring and management of the high-risk case.

17. **It is recommended that the Ministry of Community Safety and Correctional Services, Policing Standards Section either develop a stand-alone model to manage high risk domestic violence cases, or include domestic violence in the current standard that addresses high-risk cases.**

The Model Police Response to Domestic Violence is the minimum standard for police in Ontario. It does not specifically address the management of "high-risk" domestic violence cases. While there exists a guideline for Police Response to High-Risk Individuals, this guideline is not specific to domestic violence cases. Although some of the investigative techniques outlined in this document could be used in domestic violence cases, it does not address the unique management requirements of a high-risk domestic violence case.

18. It is recommended that police services put processes into practice to ensure that 911 call-takers and dispatch personnel receive specialized training in domestic violence. Guidelines should be established with prioritized questions to assist 911 call-takers and dispatch personnel to assess immediate risk to the caller and to first responders.

In one case, the victim was on the phone with 911 when the offender arrived at her place of residence. The responding police were rapidly dispatched, arriving within minutes of the call, and arriving at the residence just as the perpetrator entered the residence to kill the caller and himself. The committee had the opportunity to review the call, which revealed a very quick development of events. There is no indication that anything could or should have been done during the call that would have effected a different outcome. However, based on the case, the committee determined that a template consisting of a series of questions specifically for domestic violence calls, much like the templates used in medical emergency calls, would help to fully assess the nature of the emergency and provide valuable information to the responding police officers. The Domestic Violence Occurrences section of *The Provincial Adequacy Standards Manual 2000* discusses a call-taker asking appropriate questions to establish the level of risk the caller may be in.[10] A template or guideline would assist the call-taker to accomplish this goal. It is also noted that 911 calls are frequently used as evidence in domestic violence prosecutions, and the information obtained during the call may be of value in that process as well.

19. It is recommended that a protocol be established between police and Crown counsel to ensure that persons proposed as surety: 1) be properly investigated as to their suitability to act as surety; 2) be fully informed about their responsibilities as surety both in writing and on the court record; and 3) be warned, in writing and on the court record, as to their potential liability under estreatment and as party to a criminal offence in the event they breach their duty.

One of the issues that arose in a number of cases that gave the committee cause for concern involved sureties and their role in the release of perpetrators who later murdered their partner or their child and take their own lives. Several of the cases reviewed identified weaknesses in the screening process of sureties who act in support of bail applications. It was apparent that the sureties in these cases were inappropriate due to having criminal records, being unable to exercise control over the accused, failing to contact the police when the accused failed to comply with conditions, and lacking understanding of the consequences of failing to meet the obligation of being a surety. In one particularly tragic case, the surety was a party to the breach that led to the homicide. In fact, after leaving court following the granting of bail, the surety drove the accused directly to the home of the victim. The accused shot his wife in the presence of their daughter and then took his own life in the same manner. In another case, the surety was the father of the perpetrator's wife. He provided a false name, as he believed he would

[10] Police Services Act, *Adequacy Standards Manual 2000*, Domestic Violence Occurrences Section #8.

not be approved as the father of the victim. The accused was released on bail and later murdered the surety's grandson.

20. Is recommended that, in cases of domestic violence, the police give persons proposed as surety written or video information about the risk factors for potential lethality, and that receipt of that material be confirmed on the court record.

The committee observed that in a number of cases where bail releases occurred in high-risk circumstances, sureties might have made a difference in preserving the lives of the victims had they acted in compliance with their obligations to report breaches. There were instances of sureties being aware of non-contact breaches with the victim, but they did not report the breach or seek to revoke their surety. In one case, a son-in-law and daughter of the perpetrator who acted as sureties failed to report the perpetrator's non-contact breaches or not residing where he was required out of fear of hurting their father or causing him to be incarcerated. In another instance, the surety—who had a criminal record and with whom the perpetrator was to reside—drove the perpetrator on his release directly to the home of the victim. In both cases, the perpetrators killed their partners within days of the violations. In another case, a person who posed as another person was approved as a surety without identification.

As an example, consideration should be given to requiring potential sureties to watch an educational videotape detailing their obligations and responsibilities before they are approved as sureties in cases of alleged domestic violence. The video should also include information about risk factors the surety should be aware of.

21. It is recommended that a protocol be established for immediately entering restraining orders into the CPIC (Canadian Police Information Centre) system so that if there is a breach, the police can act immediately under the Family Law Act.

It is not uncommon for parties who are separating to seek a restraining order in the family court. Such orders usually provide that the respondent be restrained from contacting the applicant, visiting the residence, or harassing the applicant. These orders also deal with custody and access conditions. Many domestic violence victims are not involved in the criminal justice system, but may be involved in Family Court about child custody or seeking protection by application for a restraining order. Concerns have been expressed that civil orders from the Family Court are not taken as seriously and may not be enforced by the police. As an example, in one case we reviewed, the accused had been breaching his conditions on his restraining order for several months. These breaches had been reported to the police, but no action had been taken. The order in this case had not been entered into CPIC (Canadian Police Information Centre) prior to the homicide.

22. **The committee recommends that the provincial policy stating that, upon conviction for a domestic violence offence, the Crown seek an order requiring an offender to attend a batterer intervention program such as Partner Assault Response (PAR) as part of a probation term be followed.**

In one case we reviewed, an accused person had been convicted of assault and was not ordered to attend a PAR program. Current provincial policy with regards to the operation of the Specialized Domestic Violence Courts requires that convicted offenders be directed into PAR programs as a part of their sentence. These are important socio-educational programs that can help increase victim safety by: 1) intervening with the offender; 2) providing education for the offender; 3) monitoring the offender on an ongoing basis; and 4) ensuring contact with the partner.

Child-Related Issues:

23. **It is recommended that the province review the *Children's Law Reform Act* and work in collaboration with the federal government's review of the *Divorce Act* to ensure that domestic violence is given a prominent role in judicial decision-making when considering child custody. Similarly, the *Child and Family Services Act* should also be reviewed to ensure consistency with the legislation noted above in requiring specific consideration of the presence and effect of domestic violence in custody matters.**

Currently, half of the states in the U.S. have a legislated rebuttable presumption against a domestic violence perpetrator having custody or joint custody of children, which should be considered in Ontario.

24. **It is recommended that before deciding on the nature of access, assessment reports for Family Court judges, prepared by qualified assessors with domestic violence training, should be considered. This assessment is especially valid when dealing with someone who has a history of domestic violence as demonstrated by a prior criminal record for related offences.**

Although professionals and the general public are beginning to understand the impact of domestic violence on children, there appears to be an inconsistent application of this knowledge in the assessment and intervention strategies we reviewed. We understand that some children who are exposed to domestic violence may suffer serious emotional harm that may be comparable to children who are abused directly. These children may be exposed to inappropriate role models in their families, and be impacted in their development of future trust relationships. The potential harms that result have been documented in both short-term and long-term consequences.

In the area of domestic homicides, children may witness extreme violence and death. U.S. and Canadian studies suggest as many as one-quarter of homicides have children present. Children are also in danger of becoming homicide victims themselves as the

perpetrator may kill children as part of an overall homicide–suicide plan, or kill children to punish their estranged partner for leaving the adult relationship. We reviewed two such cases in 2004, where a toddler's homicide was a direct act of revenge for a woman seeking to end an abusive relationship. Both of these tragic circumstances reflect the lack of clarity in law and practice on how to intervene with children exposed to domestic violence.

One area that needs to be addressed is the role of the Children's Aid Society (CAS). In responding to domestic violence calls involving children, current practice by police in Ontario involves sending a copy of the occurrence report to the CAS for their investigation. The CAS intervention varies, depending on a number of issues such as local practice and protocols as well as the nature of the circumstances. A common circumstance in potentially lethal cases is parental separation. The CAS worker has to decide whether this is a case that requires their protection and/or counselling mandate, or whether the case can be managed in the private custody and access sector involving other resources such as family law specialists, supervised access centres, mediators, and custody evaluators. The CAS decision also happens in a context of not wanting an abused spouse to feel re-victimized by the intervention (e.g., You're an abuse victim but also a bad parent for letting your child live with this violence). Without assigning blame in the cases we reviewed, it appeared that the CAS workers were well-intentioned in their contact with the abuse victim, but failed to assess the perpetrator, support safety planning or risk reduction, or coordinate their efforts with other professionals.

Some confusion exists in the field regarding roles and responsibilities in dealing with children in the context of domestic violence. The criminal court properly assumes innocence until the allegations are proven beyond a reasonable doubt. The process of preliminary hearings and trials may take many months, and in some cases may take years. However, the victim and children may need an immediate safety plan that either suspends contact with the perpetrator or requires supervised visits or exchanges between the parents. The challenge to the court system and community services is how to manage such a plan and respect the presumption of innocence. The Family Court can make interim findings on the balance of probabilities if proper evidence is presented. Some scepticism is usually found within the courts when one parent raises allegations of abuse against the other parent and tries to limit contact, since the system depends on friendly and cooperative parents willing to put the past behind them in the best interests of the children. This approach is counter-intuitive for a domestic violence victim who is seeking safety and an end to the violence. The CAS may also be sceptical that they are being drawn into a private family law dispute with allegations being made by separating parents.

The cases we reviewed illustrate many of the points outlined above. Access was offered in cases where there should have been none, or where there should at least have been strictly supervised visits. The criminal court and family court did not coordinate their services or interventions. It was unclear whether the CAS should intervene or leave matters to private child custody proceedings. The CAS appeared to focus on the basic care of the children rather than the danger the perpetrator continued to present. There

were no systematic approaches to risk assessment and risk reduction. Violations of court orders were ignored or seen as low priority in the face of a disconcerting pattern of behaviour that could have been readily identified at the time. There seemed to be a lack of any comprehensive assessment that addressed the risks that the victim and her children faced in the context of domestic violence. Ultimately, it was unclear who was in charge of the case and who was accountable.

25. **It is recommended that child welfare and protection agencies screen for domestic violence in all cases. As part of the process, it is necessary for them to locate, interview, and assess all partners involved. Where there is evidence of domestic violence, they must take the necessary steps to use their authority under the Children and Family Services Act to make appropriate interventions with the abuser to protect the mother and child.**

26. **It is recommended that the province develop a discussion paper and inter-ministerial guidelines for all cases involving domestic violence, children and custody, or access disputes. The paper and guidelines should encourage enhanced coordinated practices and protocols within and between the family and criminal courts, as well as court-related services such as victim–witness services, mediation, supervised access, CAS, batterer intervention programs, and probation supervision.**

An effective response to domestic violence requires not only well-informed individual interventions, but also coordination of services by different professionals involved with family members. Previous research on intervention strategies with perpetrators of domestic violence has reinforced the notion that the "system matters" and successful outcomes are more likely with the justice system and community services working together.[11] In eight of the nine cases we reviewed, tragedies may have been averted if different individuals had had an opportunity to put risk factors together as pieces of the same puzzle, rather than appearing to be isolated and unconnected incidents. At the same time, in retrospect, interventions by individual professionals lacked the effectiveness that might have been achieved with genuine collaboration.

Several of the 2004 cases highlighted the need for ready access to critical information, such as having restraining orders placed in a timely fashion on CPIC (Canadian Police Information Centre) to help subsequent police interveners recognize a potential red-flag situation. Several cases we reviewed suggest the importance of coordination of information and interventions within family and criminal law proceedings. Families in which domestic violence occurs may find themselves in three different streams of court proceeding: criminal, child custody, and child protection hearings. There is considerable confusion about the roles and responsibilities of the latter two systems regarding when domestic violence is an issue for state intervention (e.g., the CAS on behalf of provincial

[11] Gondolf, E. W. (2002). *Batterer Intervention Systems: Issues, Outcomes, and Recommendations*. Thousand Oaks, CA: Sage Publications.

child protection legislation) versus an issue for parents to settle privately through provincial laws for custody and access post-separation. There appears to be no formal mechanisms in place to foster communication between the family court and criminal court in coordinating issues around child custody and safety of individual family members. These cases raise the importance of understanding the special circumstances surrounding children exposed to domestic violence and the fundamental relationship between victim and children's safety.

c. Resources

27. It is recommended that when a case is identified as "high risk," an appropriate immediate response is necessary, requiring adequate resources to effectively respond to and manage the risk.

In one of the cases, the mother of a missing child had to physically go to the police station and beg the police to start an investigation. It was reported that the officer that spoke to the mother responded in a frustrated and confused manner and seemed unsure of the correct way to proceed. The protocols already in place under the *Police Services Act, Domestic Violence and Missing Persons* should have been immediately implemented. The investigating officer from a large urban police service advised the committee that his jurisdiction had a large number of domestic violence cases, at least five reports per shift, and the officers felt frustrated because they did not have adequate personnel to respond effectively.

28. It is recommended that additional resources be made available to develop or provide access to domestic violence services for people living in northern (rural and remote) communities.

In reviewing the cases of the past year, it became apparent that the accessibility and availability of domestic violence services for people residing in rural and remote northern communities is gravely lacking in comparison to domestic violence services available in the more populated southern communities. Resources should be made available to develop domestic violence services that are culturally specific and appropriate for the population served. Services should be delivered to the community where domestic violence services are needed, and/or the people requiring domestic violence services should be provided with transportation to areas where such services can be accessed.

29. It is recommended that appropriate resources be allocated to implement those recommendations herein directed to the training and provision of the necessary tools to protect children and assess the risk associated to domestic violence.

The committee has made a number of recommendations identifying a need for resources for training within child welfare and protection agencies. In addition, other agencies in a position to provide valuable assistance to the courts when these courts are called to render decisions require resources and training to help them administer appropriate assessment

tools and techniques. Four of the nine cases reviewed by the committee involve parents who were engaged in custody and access disputes. In two instances children were murdered, and in one of those cases and in a number of the other cases children also became surviving victims of domestic violence who suffered the loss of a parent and/or a sibling.

Chapter 5 – Subcommittee Report

In recognition of the recommendations made in earlier inquests and issues arising from the case reviews about the need for appropriate risk assessment tools to help identify the potential lethality of a situation, the DVDRC created a subcommittee to survey existing and proposed risk assessment instruments. In the last report of the DVDRC, we reported on that survey of instruments and recommended using the *Domestic History Questionnaire* to assist in collecting relevant contextual information. The information gathered through a series of focused questions would be useful, not only for assessing the level of risk and danger that the victim may be exposed to, but it also has potential evidentiary value for those engaged in the criminal justice system. Further, it could be useful for those trying to help the victim develop a safety plan. It is intended that the form be modified to suit the needs of the agency or organization using it. The subcommittee is currently working on an instructional guide to accompany the *Domestic History Questionnaire*.

As a result of the case reviews this year, the subcommittee observed there is a lack of coordination and follow-up of domestic violence cases, as well as a lack of continuing vigilance—particularly in the justice system—pending completion of the case. When serious injury or death occurs, the unacceptable but common response is that the case fell through the cracks. Unfortunately, a number of the tragic cases that result in fatalities occur when the perpetrator is subject to a bail order or the victim has obtained a restraining order. As a result, the focus of attention of the subcommittee this year has been on the need for a process to provide some measure of safety to victims: a process that would help limit the risk.

This chapter describes a basic case management framework, as well as a preliminary examination of a number of different approaches that have been used by some communities in an effort to manage high-risk cases. The following does not purport to recommend any particular approach. Over the next year, we intend to conduct a more extensive survey of approaches from a number of jurisdictions to determine the best practices in the area. On the basis of that survey, our committee hopes to develop a more comprehensive manual on how high-risk cases could be managed.

Management Of High-Risk Cases

Once a high-risk case has been identified, it is critical that there be a process to actively manage the case to minimize risk of future violence. In recent years, advances have been made to help determine which cases qualify as high-risk cases. Since high-risk cases are situational, it is imperative that a management plan be implemented immediately to positively intervene to prevent lethal violence taking place. In many domestic homicide cases reviewed by our committee, numerous pre-incident indicators were present that

signalled imminent harm to the victim. Unfortunately, these indicators were neither understood nor acted upon to trigger a management response.

Interviewing the Victim to Ascertain Risk

Victims play a critical role in the identification of high-risk cases and in the management of those cases. Many victims experience fear intuitively and have a clear understanding of what their partner is capable of doing. Some victims may be complacent to the imminent danger they are in, but may provide an excellent source of information for others to act upon. Whatever the situation, to effectively manage a high-risk case, it is necessary to determine what harm may befall the victim. Accordingly, victims should be interviewed as soon as possible and, in some cases, immediately. Our committee has recommended that the *Domestic History Questionnaire* be used as part of this interviewing process.

Typically, a victim is first asked about biographical details and then is asked about the current incident. The interview then turns to the completion of the *Domestic History Questionnaire*. A police officer asks the questions and the answers are recorded on the form. The form is then available for use before a decision to release is made by the police or by the Crown. The document would also be available for bail court. It is recommended that the entire interview be videotaped, under oath, to preserve the evidence. This is especially desirable should the victim later decide to recant. There have been a number of cases where victims had been thoroughly interviewed on videotape, disclosing clear and imminent danger to their lives, and yet law enforcement and the prosecution never viewed these videotapes or never used the information from them to develop a management plan. Tragically, many of these cases resulted in lethal violence that could have been prevented. It is therefore imperative that any model designed to manage high-risk cases must focus on the victim and must include information on risk that the victim has disclosed.

Basic Practices

Most communities without formal case management models attempt to manage cases through the use of bail. Ideally, once a case is identified as high-risk, a thorough and complete bail brief is prepared to support an effort by the prosecution to seek a detention order. Keeping an accused person in custody is one way to prevent a domestic homicide. The reality is that few cases result in detention orders, and many cases result in the release of the accused into the community. This may occur should the police wish to exercise their discretion to release a person on conditions by way of an undertaking.

If an accused person is held in custody for a bail hearing, the Crown may consent to the person's release with conditions. Should a bail hearing actually take place, a judicial officer may release a person with conditions. Whatever the case, if an accused person is

released, there should be stringent bail conditions and the need for a surety. The following conditions should be considered:

- Geographical restrictions
- No contact with alleged victim(s)
- Curfew
- No alcohol or non-prescribed drugs
- No firearms, ammunition, explosives, or any weapons
- Not to operate a motor vehicle if vehicle involved in the offence
- Electronic monitoring as per the Hadley Inquest recommendations
- Report to the police
- Notify the Court of any change of address

Sureties

Our committee is of the view that sureties should play a greater role in the management of accused persons in the community. When a person is on bail with a surety, the role of a surety has been likened to that of a keeper of a detention centre. A surety is responsible to ensure that there is compliance with all bail conditions. Sureties are under an obligation to call the police in the event of non-compliance or apply to the court to be released as a surety.

It is important that sureties be reliable and responsible persons. Not only is it important for sureties to pledge valuable security as part of a bail release, but sureties should also have a clear understanding of their role to help ensure that alleged victims will be safe from harm. In this regard, sureties should be required to learn about lethality indicators, which may precede a lethal act. They should be educated on what they need to do should they recognize danger signs. They should have available a telephone number that they can call so immediate action might be taken by the authorities. It is recommended that the potential surety be obligated to watch an educational videotape dealing directly with dangerousness in domestic violence cases.

Basic Management Techniques While the Case Is Pending

Regardless of whether a formal case management model is in place, it is recommended that police agencies undertake some basic management techniques to safeguard victims. All victims of domestic violence should be promptly notified of bail conditions and a safety plan should be undertaken. In some cases, it is also important to notify the victim's family, work, and the schools of any children. The victim should be warned to be wary of individuals acting on behalf of the accused. Ground rules should be established with the victim so that the victim contacts the police for even what may appear to be insignificant events such as hang up calls, drive-bys, and disturbances to the outside or inside of the house. The victim should be asked to maintain a log of any suspicious events.

The police should ensure that all conditions of bails are entered on CPIC (Canadian Police Information Centre) record system. As well, any Family Court restraining orders should be entered on CPIC. In appropriate cases, the police should undertake physical and electronic surveillance. They should have regular contact with the victim. They should consult with their Threat Assessment Unit or other experts, such as the Behaviour Sciences Unit of the Ontario Provincial Police. There should be a system whereby one officer is responsible for the high-risk case. That officer should be notified of any incidents involving the accused or the victim reported to other officers. This would ensure that the case manager is aware of any developments and takes appropriate action.

Service Delivery Model (Huron County)

In Huron County, the Ontario Provincial Police has undertaken an innovative service delivery model in an effort to deal with high-risk cases. There are four platoons responsible for policing in the county. One officer per platoon has been designated an Abuse Issues Resource Officer. That officer has received training in criminal investigation, child interviewing, sexual assault, and domestic violence. Each Abuse Issues Resource Officer is responsible for assisting in the investigation and monitoring of cases of domestic violence that occur while their platoon is working. A platoon consists of twelve officers. Each Abuse Issues Resource Officer ensures that proper investigative procedures are followed, proper bail conditions are applied for, and that there is general quality control. The goal is to deliver a more seamless police response to domestic violence. With respect to high-risk cases, the Abuse Issues Resource Officer would have carriage of the case. These officers are to be notified of any incidents involving the accused or victim by way of SIP (Special Interest Person) entries on CPIC, the Occurrence Report Management System, and by email.

Team Approaches To Case Management

It is recommended that perhaps the most effective way to manage high-risk domestic violence cases is to have a team approach. Some communities have established dedicated teams within their police departments who specifically manage high-risk domestic violence cases. These dedicated teams consult and work with community-based agencies. Other communities have established a coordinated approach involving a number of agencies to manage high-risk cases. The subcommittee is in the process of reviewing responses from police agencies across Ontario concerning any domestic violence high-risk case management protocol that may exist. Once all responses have been received, a detailed analysis of best practices will be compiled and reported on. Until this process is complete, it may be useful to outline a number of domestic violence high-risk case management models that have been implemented in large and small jurisdictions.

Intimate Violence Enhanced Services Team (INVEST)

INVEST was established in Jacksonville, Florida, to identify and intervene in the most potentially lethal domestic violence cases. The team is comprised of two police officers

and two social workers. All domestic violence police reports and referrals from other agencies are reviewed and assessed for potential lethality. Advocates and sheriff's officers who work together to provide services to victims and perpetrators follow up cases identified as high-risk for lethality. INVEST clients receive intense case management and advocacy. For more information, visit *http: www.coj.net*

Domestic Violence Enhanced Response Team (DVERT)

DVERT was established in Colorado Springs, Colorado, to ensure the safety of high-risk lethality victims. DVERT relies on a multi-level, multi-disciplinary case management approach. The team consists of criminal justice officials, non-profit organizations, victim advocates, and city and county human service agencies. DVERT involves efforts to establish communication among criminal justice and social service agencies to establish advocacy services to meet victim's needs, and to implement policies aimed toward more aggressive apprehension and sanctioning of offenders. The DVERT program focuses on three levels of domestic violence situations:

- Level One – the most lethal situation where the victim may be in serious danger
- Level Two – a moderately lethal situation where the victim is not in immediate danger
- Level Three – a lower lethality situation

DVERT uses an intake team, an assessment team, and an ongoing contact team. For more information, visit *http: www.dvert.org*

Hamilton Police Service High Risk Domestic Violence Operational Team

During the latter part of 2003, the Victim Services Branch and the Family Violence Resource Unit of the Hamilton Police Service recognized the need to identify and manage high-risk domestic violence cases. The High Risk Domestic Violence Operational Team and the Community Advisory Team of the Hamilton Police Service were developed as a result.

The High Risk Operational Team is comprised of two detectives from the Family Violence Resource Unit, the coordinator and administrator from the Victim Services Branch, and a detective from the Bail Pilot Project at the courthouse. The team meets each Tuesday to determine which cases will be considered high risk and how to manage them with action-oriented plans (e.g., contacting probation to ensure intensive supervision; discuss surveillance regarding High Risk Wanted Offenders; prepare threat assessments background information to be forwarded to the O.P.P.; safety planning). The team reports to the Investigative Services Division inspector. The High Risk Operational Team has been meeting weekly since the spring of 2004.

The Community Advisory Team was introduced in October 2004 (on a pilot basis). Members of a number of agencies were invited to attend to represent both victim- and offender-based programs (e.g., CAS, corrections, VWAP, probation, Canadian Mental Health, men's anti-violence, women's shelter, etc.). The team is still in the development

stage as individual agencies are finalizing their decisions to participate. Participants are required to sign a Memorandum of Understanding. Once the team members are finalized, they will participate in the review all high-risk cases and help develop an approach to dealing with high-risk offenders and victims of domestic violence.

High-Risk Action Review Team, Belleville, Ontario (HART)

HART was established in December 2002. The team consists of the Domestic Violence Assistant Crown Attorney, the manager of the Victim Witness Program, and a police officer who is the Domestic Violence Coordinator. Only cases where criminal charges have been laid are referred to the team. The team meets by teleconference every second Tuesday. The Victim Witness Program manager is the coordinator and maintains the list of cases. Any agency working with the victim may suggest a review. A review may lead to follow-up and further investigation.

Partner Assault Support Team, Ottawa (PAST)

In 1997, PAST was implemented in Ottawa to promote a coordinated criminal justice system response to partner assault cases. PAST membership consists of the police, the victim crisis unit, prosecutors, the Victim Witness Program, regional social services, CAS, and probation. All team members are responsible for referring high-risk cases for review and providing information about their involvement in each case review. High-risk cases are reviewed on a weekly basis. Concerns are identified and action is taken, including follow-up.

The Ottawa Police Service has a specialized domestic violence unit consisting of fifteen detectives, four sergeants, and one staff sergeant. All domestic violence incidents are subject to daily assessment by the unit case manager, with immediate priority to high-risk files. The Partner Assault Unit participates in weekly meetings with PAST.

High Risk Consult Team, Woman Abuse Council of Toronto (WACT)

WACT is a policy development and planning body with a mandate to develop a coordinated response to woman abuse. Since 2000, WACT has created a *High-Risk Tool Kit* that provides resource materials about potentially lethal situations. The kit outlines a case management model recommended for high-risk cases. Over 40 agencies in Toronto have been trained with this kit. In 2003, WACT formed the High Risk Consult Team to provide expert consultation to front-line practitioners who are struggling with high-risk and potentially lethal cases. The team is an inter-disciplinary group of practitioners, all of whom have extensive experience working with abused women and their families.

Any agency staff person in the community can contact WACT for assistance. A thorough interview is completed, a high-risk assessment is undertaken, and a review takes place of what interventions have already been attempted. If the case is complex and high risk, the

case is brought forward to a monthly meeting of the consult team. Cases are presented without identifiers before the team. While safety planning is important, the team also focuses on the abuser. The team assists front-line practitioners by providing opportunities to learn about possible interventions through various sectors. The team shares creative ways of working with abusers and women victims. The team develops its collective wisdom as cases are discussed and recommendations for interventions and approaches are identified. For more information, visit *http: www.womanabuse.ca*

Huron Assessment Risk Reduction Team (HARRT)

HARRT was established in 2004 in Huron County. Membership of HARRT consists of the Crown Attorney, police, the women's shelter, CAS, mental health, Victim Witness Program, and probation. HARRT was created in response to the recognition that many murder/suicide cases result from the accused being chronically depressed, with little support and having nothing to live for. HARRT is of the view that in some cases, it may be extremely helpful to bring together persons from the community in a non-adversarial setting to help the accused and protect the victim. Any member of HARRT may refer a case for review. Once a high-risk case is identified, any team member can arrange an ad hoc conference call.

Chapter 6 – Implications and Future Trends

In our second year as a committee, we were able to complete nine comprehensive reviews of domestic violence homicides. When compared to our previous year, we found many of the same trends. Most remarkable was the fact that eight out of nine cases appeared predictable and preventable with the benefit of hindsight and our analysis. The vast majority of cases had seven or more risk markers that are commonly found in the literature on assessing lethal domestic violence.

We were able to review four cases that involved the complexity of criminal and family law proceedings. These cases present a challenge for collaborative efforts to keep victims and their children safe. Two cases involved fathers killing toddlers to punish their wives for leaving an abusive relationship. These cases call out for enhanced risk assessment, safety planning, and risk reduction as outlined in many of our recommendations as well as Appendix A, the recommendations from our last report. These cases also highlight the dangers facing children in the context of domestic violence by the direct and indirect impact of this violence.

The work of our committee has attracted many inquiries from other jurisdictions across Canada and the United States. The chairperson and other members, have been called on to present at provincial, national, and international conferences on the findings from our first annual report. Senior government officials in two provinces have expressed interest in developing a similar committee in their jurisdiction. Outside observers have commented on the thoroughness of our review process, made possible by working within the legislative and operational structure of the Office of the Chief Coroner.

Our committee members have a passion to save lives by learning vital lessons from the horrific tragedies we review. We believe that the results of our reviews are making a difference. One of the longest-standing domestic violence death review committees was founded in 1994 in Santa Clara County, California. There is some evidence of a reduction in homicides, associated with the committee's work. In their most recent annual report entitled "Speak up – Save Lives," they state:

> *We also did not lose one person who had a restraining order or had a reported on-going criminal case with law enforcement. We are convinced that law enforcement is doing a great job in terms of its response to domestic violence situations and that prosecution of these cases saves lives. There was also an increase last year in citizen's calls to law enforcement in domestic violence cases. We will continue to track and study domestic violence related death cases and we are convinced that this work saves members of our community from early and tragic death.*

It is our hope that the work of the committee and action taken in response will have the same impact in Ontario.[12]

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[12] *Speak-up – Save Lives*, Santa Clara County Domestic Violence Council (2005) Death Review Committee Final Report, January 1 – December 31, 2004. San Jose, CA: Author, p. 14.

Committee Membership

Al J.C. O'Marra, B.A., M.A., LL.B., LL.M.
Committee Chair
Chief Counsel, Office of the Chief Coroner
Coroner's Counsel in the May/Iles and Hadley Inquests

Claudette Dumont-Smith, R.N., B.ScN., M.P.A.
Hull, Québèc
Former member of the Aboriginal Circle Against Family Violence
Aboriginal Health Consultant

David Eden, M.D.
St. Catharines, Ontario
Regional Supervising Coroner, Niagara Region, Office of the Chief Coroner

Jim Farrell
Barrie, Ontario
Inspector, Barrie Police Service
Established Barrie Police Service's Domestic Violence/Sexual Assault Unit.
Authored police procedures on domestic violence, criminal harassment, bail and violent crime, parental and non-parental abductions, and victim assistance.

Len Favreau, M.A.
Peel Region, Ontario
Inspector, Peel Regional Police
Past member of the Peel Committee Against Woman Abuse (PCAWA)
Member of the Solicitor General's Policing Standards Branch working group that established new standards for police response to domestic violence and criminal harassment.

Vivien Green
Toronto, Ontario
Executive Director, Woman Abuse Council of Toronto
Member of Ontario Government commissioned Joint Committee on Domestic Violence

Peter Jaffe, Ph.D.
London, Ontario
Professor, Faculty of Education, University of Western Ontario
Academic Director, Centre for Research on Violence Against Women & Children
Director Emeritus, Centre for Children & Families in the Justice System of the London Family Court Clinic

Beth Jordan
Toronto, Ontario
Managing Director, Adobe Consulting Services
Former Director of Programs & Services, Assaulted Women's Helpline

Barbara Lent, M.A., M.D., CCFP, FCFP
London, Ontario
Associate Professor, Department of Family Medicine, Victoria Family Medical Centre, University of Western Ontario

Robert Morris, B.A., LL.B.
Goderich, Ontario
Crown Attorney, Ministry of the Attorney General.
Co-founded the first Domestic Assault Review Team (DART) in Canada.
Implemented the first questionnaire in Ontario to identify risk and potential lethality for domestic assault victims.
Helped establish the Huron Assessment Risk Reduction Team (HARRT) in Huron County.

Susan Physick
Toronto, Ontario
Manager (former) with the Victim/Witness Assistance Program
Developed Early Intervention Programme for Young Offenders in dating relationships, the R.S.V.P. (Relationship Skills in Violence Prevention).

Bonita Porter, B.Sc., Phm., M.Sc., M.D., C.C.F.P.
Toronto, Ontario
Deputy Chief Coroner – Inquests

Deborah Sinclair, M.S.W.
Toronto, Ontario
Founding member of the Emily Stowe Shelter for Women
Consultant to Durham Region's Violence Prevention Co-ordinating Council
Author of *Understanding Wife Assault*, *In the Centre of the Storm*, *Durham Speaks Out* and other articles and papers related to violence against women and children.

Kevin Sisk, B.A. LL.B.
Barrie, Ontario
Assistant Crown Attorney, Ministry of the Attorney General
Former Domestic Violence Coordinator for Simcoe County Crown Attorney's office
Member Domestic Assault Review Team (DART)
Assistant Crown Attorney since 1991

Dawna Speers
Mississauga, Ontario
Executive Director, The Speers Society
The Speers Society is committed to the prevention of youth relationship abuse through education and support. *http://www.speerssociety.org*

Renee M. Pomerance, BSc., LL.B.
Toronto, Ontario
National Judicial Institute representative
From August 2002–December 2003, served as legal counsel to the Honourable Peter Cory on an inquiry into six murders that occurred in Northern Ireland.
Crown Counsel in the Crown Law Office – Criminal since 1989

Filomena Williams
Aurora, Ontario
Former Executive Director, Yellow Brick House

Thomas Wilson, M.D., C.C.F.P., M.H.S.C.
London, Ontario
Regional Supervising Coroner, Office of the Chief Coroner, Southwestern Region

Ex Officio

Barry McLellan, M.D., FRCPC
Chief Coroner of Ontario

Jim Cairns, M.D.
Deputy Chief Coroner

Regional Supervising Coroners:

William Lucas, M.D., C.C.F.P. – Central (Brampton)
Karen Acheson, M.D., C.C.F.P. – Central West (Guelph)
Andrew McCallum, MD., FRCPC – Eastern (Kingston)
Peter A. Clark, M.D. - Northeastern (Peterborough)
David A. Legge, M.D. CCFP FCFP BSc. (Med.) – Northwestern (Thunder Bay)
Jim Edwards, M.D. – Toronto East
David H. Evans, M.D., M.B.B.S., F.R.C.S.C., F.A.C.S., D.A.B.U. – Toronto West

OCC Staff:

Tom Girling
Executive Officer

Julie McCreary
Administrative Assistant

Appendix A

Recommendations from the First Annual Report of Case Reviews, 2002

This report is based on the cases the committee reviewed during meetings in 2003, and includes all 2002 Ontario domestic violence deaths as defined in the committee's mandate, except a significant proportion still before the courts. The following recommendations are based on the specific cases reviewed in the committee's first year. The limited or narrow focus of the recommendations in this report are derived from the specific case reviews, and should not be seen as diminishing or detracting from the recommendations or reports of previous inquests in this area.

The recommendations made by the committee fall into three major subject areas of potential intervention, all addressing heightening and increasing **awareness and education**, **assessment and intervention**, and **resources.**

Firstly, there is a need to heighten awareness and provide education about domestic violence. In every case review we examined, family members, friends, neighbours, and/or professionals had some knowledge of the escalating circumstances between the perpetrators and victims. However, these individuals did not appreciate the significance of the situation, the information available to them, or what to do about it. Accordingly, many of the recommendations address the continuing need for targeted public awareness and professional educational programs that teach about the signs of domestic violence and the risk factors leading to potentially lethal consequences.

Secondly, there is a need to have appropriate tools available to those who work with victims and perpetrators of domestic violence to better assess the potential for lethal violence in their lives, and corresponding access to appropriate services and programs. As an example, victims may need assistance with safety planning and perpetrators may need access to counselling programs or the need of restrictions to control their behaviour to better manage the risk.

Thirdly, adequate resources are required to ensure victim safety and reduce perpetrator risk. All programming and services require resources to become operational. These include, but are not limited to:

- support for helping the victim to be removed from the situation;
- affordable alternative housing;
- counselling services for victims and families; and
- other community-based support systems for victims and perpetrators and children exposed to domestic violence.

These areas for intervention are links in a chain—if one or more is weak or absent, the chain breaks, and opportunities for prevention are lost. In many of the cases reviewed, one or more of these links were present, but an adverse outcome was attributable to the absence of another. For instance, a properly performed risk evaluation is of little value if the police or others do not use it for safety planning, or the admissible information on which it is based is not brought before the criminal courts when necessary.

Awareness and Education

As observed in the verdicts of several inquests and in the Report of the Joint Committee on Domestic Violence, there is a continuing need to heighten awareness and provide educational programs that focus on the signs of domestic violence, including the risk factors that may lead to lethal circumstances. This awareness and these programs should also focus on the necessary individual and community response by:

- the general public (friends, neighbours, relatives, employers, family, community leaders, as well as the victims and perpetrators themselves);
- all front line professionals (teachers, lawyers, clergy, social workers, etc.) who, in the course of their work, come into contact with victims, perpetrators, or the children of domestic violence;
- professionals whose primary function is to serve victims of domestic violence (such as police officers and healthcare professionals).

We can draw conclusions from our reviews as to whether or not homicides with similar presenting factors could have been predicted or prevented. In 5 of the 11 cases reviewed, a domestic homicide would likely have been predicted if similar facts were presented to professionals knowledgeable about domestic violence. In 6 out of 11 cases, a domestic homicide would not have been anticipated per se. Nonetheless, in these cases, a tragedy may have been prevented in similar circumstances by intervening with the stressors being experienced by individuals or family conditions that ultimately became a factor in the homicide.

1. **There is a need to better educate the public about the dynamics of domestic violence and appropriate responses where such dynamics are recognized in potential abusers or victims.**

It is troubling to the committee that the inquests and other reports on domestic violence have seen the need to continue to address this issue. We note that the Ontario Women's Directorate and outside agencies have sponsored excellent campaigns, however there is a need for a more widespread, ongoing and consistent strategy of public education efforts. In eight of eleven cases reviewed by the committee, family, friends, or neighbours observed indicators of domestic violence in either the victim or perpetrator or both. Notwithstanding their concerns, they neither recognized the significance of those indicators, nor did they act upon them. In each case, risk factors were identified on review. In nearly half of the cases, four to more than ten risk factors were present.

The implementation and use of effective public education programs need to be increased to heighten awareness of the warning signs of symptomatic abusive behaviour and appropriate courses of action for victims, perpetrators, and others to take in response. All too often, domestic violence is only recognized as physical abuse. Emotional abuse also needs to be recognized, such as jealousy, economic abuse, intimidation, threats, controlling behaviours, and isolation.

Domestic violence public awareness programs should contain features directed to increasing awareness that the non-reporting of abuse by victims, or threatening behaviours of perpetrators, can not only impact their own safety, but the safety of others close to them. Non-reporting can also impact the safety of others who later enter into relationships with the abuser. It was noted in one case that as many as three prior victims resided near the perpetrator, however not all had reported the abusive behaviour. In some instances, it was not until the aftermath of the domestic violence death that other victims of abuse divulged information.

2. **Public education should target potential victims and perpetrators of domestic violence. The education should:**
   - **include the fact that risk of violence increases substantially during the time that a partner is leaving the relationship;**
   - **address the needs of depressed and suicidal men who require counselling and risk reduction interventions, such as the removal of firearms from the home to prevent the escalation of the circumstances that result in the tragedies we have reviewed;**
   - **be directed towards persons of all cultures, languages, and faiths; and**
   - **address the need to overcome cultural barriers and the feeling of "shame" as related to mental health issues, with the goal of reducing stigma.**

In one instance, a divorced spouse suffering from paranoid schizophrenia and alcoholism, with a history of verbal and physical abuse as well as the obsessive monitoring of his former spouse's activities, openly voiced suspicions to his family members about his ex-wife poisoning his food. Even though divorced, he continually stayed at his estranged wife's home. The family, fairly recent émigrés from an eastern European country expressed considerable shame about the perpetrator's mental illness, which appears to have inhibited them and his estranged wife from reaching out to community services that might have assisted. One evening, after voicing his suspicions to his son, he stabbed his estranged wife to death and hanged himself.

3. **The requirement for third parties to report child abuse when a child's safety and life is placed at risk needs to be more widely publicized.**

In one case, the committee noted that the perpetrator demonstrated an unnatural and obsessive involvement with his daughter that should have been apparent and troubling to his family and friends. He was also known to put the child at risk when he took her out with him for extended periods of time, after which he would drive his car in a highly

intoxicated condition. At the point of declared separation by his wife, the perpetrator killed himself and his daughter.

4. **There is a need for ongoing training in the issues of domestic violence and potential lethality for police, social workers/counsellors, clergy, and physicians.**

Training must deal with two issues: the first is recognizing domestic violence in all its forms—emotional, psychological, and physical—and the second is identifying high-risk situations that require intensive assessment and immediate intervention strategies. In several case reviews, the committee observed numerous points of intervention at which steps could have been taken to respond to the escalation of aggressive and threatening behaviour. Evidence was present that should have signalled to the professionals that potential fatal outcomes were possible and/or probable, however there was no apparent appreciation of the significance of the evidence or application of an assessment to evaluate its significance and the appropriate action to minimize risk to the victim.

5. **Police and other front-line workers (health/educational/social) need to be made aware of the resources available in their respective communities to address issues of family breakdown, conflict, and mental health, and to make referrals when necessary.**

In one instance, a family counsellor who was conducting sessions with both spouses directly observed the perpetrator's irrational paranoia and volatility during a session. The counsellor, however, did not discuss a safety plan with the victim beyond advising her to contact police if she felt in danger.

6. **Training workshops have to be developed and delivered by trained experts from the cultural communities being served.**

7. **Cross-cultural and cultural competence training should be a mandatory component of all training programs for front line workers, such as police, healthcare, and social workers.**

The review included a number of cases where the victims and perpetrators came from other diverse ethnic or cultural backgrounds, including people of the First Nations. Religious and spiritual leaders can play an important role in assisting their congregations to access cultural and community services to help them deal effectively with mental health and domestic violence issues. In several cases, the perpetrators had direct involvement with religious or spiritual leaders, having been sought out or referred by others due to concerns about the deterioration of their relationships with their spouse and their threatening behaviour. In one instance, the perpetrator threatened to kill himself, and in another, he threatened to shoot a person he believed was involved with his spouse.

8. Physicians require further education about the dynamics of domestic violence and the potential lethality, particularly where alcohol abuse, depression, anxiety, or suicidal ideation is present and diagnosed.

Of all the professional groups that we encountered during the case reviews, the role of the family doctor was pivotal. In many of the cases, the victims and perpetrators were involved with family physicians to deal with depression from a variety of stressors having an impact on their relationships. One case review revealed that both the victim and perpetrator were patients of one family physician for more than 20 years. While patient confidentiality is paramount and to be respected, questioning of the patient's personal circumstances might have elicited information about the spouse, particularly the perpetrator in this case, which might have created a clearer picture of the risk for violence in their lives.

Educational programs should address the following:

- Patients may talk to their family physicians with whom they have long-term relationships about the difficulties they are experiencing in their intimate relationships. Family physicians need to be aware of how common the problem of domestic violence is. In addition, family physicians should be able to assess the risk in their patients' home environments. If physicians feel they lack the skill or expertise to make such assessments, they should ensure they know of other healthcare providers or community agencies to which they can refer these patients.
- A prior history of abusive behaviour, combined with a diagnosis of depression and inappropriate use of alcohol, street drugs, or prescription drugs, should alert professionals to the strong possibility of repeated violence. In such a situation, healthcare professionals should inform their patients about the risk of the situation, and urge these individuals to seek help. Depending on their assessment of the risk and the apparent impulsivity of the abusive partner, family physicians may need to consider warning the other partner or informing the police of their concerns about the possibility of worsening violence.
- When treating patients for depression and/or anxiety, it is essential to ask about suicidal and/or homicidal thoughts, and to consider the risk of the patient acting on such thoughts. The patient's depression and/or anxiety may reflect the patient's experience of domestic violence, or may increase the likelihood of abuse. In addition, physicians need to be particularly attentive to the possibility of access to firearms or other weapons, especially when working in rural communities.
- In situations where physicians find themselves caring for both the victims of abuse within an intimate or family context and the perpetrators of the same abuse, they must ensure that the needs of the abused women and the perpetrators are addressed independently, such that their rights to autonomy, confidentiality, honesty, and quality of care are maintained. Couple or marital therapy is contraindicated unless the woman's safety can be ensured and the man has taken responsibility for his abusive behaviour.

9. School boards should institute curriculum-based healthy relationship programs as an essential part of the education system.

Educational programs should address the following:

- The program should provide a continuum of educational materials (kindergarten to grade 12) to promote building skills and strategies for positive interpersonal relationships.
- The program should include programming to develop awareness of the warning signs of abuse and the potential for violent/abusive behaviour. The program needs to recognize the different roles in which children and adolescents come in contact with domestic violence. These roles include exposure to violence at home, in the media, and in dating relationships as victims, perpetrators, and peer groups.
- School boards should enlist community resources to support and sustain healthy interpersonal relationship choices in prevention and intervention programs.
- Teachers and community agencies have a unique opportunity to collaborate on program development and implementation. By working together as a team, they have the opportunity to promote awareness, understanding, skills, and knowledge.

This recommendation arises from the nature of the cases we reviewed. In one case, the perpetrator had confessed his intention to kill his former girlfriend to a peer who did not know how to handle this disclosure. The girlfriend had been warned about the nature of the relationship by her mother and a guidance counsellor, but minimized the abuse as "only" possessiveness and jealousy. The facts of the case speak to the importance of broader curriculum initiatives that engage potential perpetrators, victims, and peers who observe abuse and receive disclosures.

In several cases, perpetrators grew up in families where child abuse and exposure to domestic violence were present. Although there was little information available about how these problems were addressed in childhood for each perpetrator, it does raise the importance of early identification and prevention programs for children in these circumstances. As well, several of our cases illustrate the dilemma adolescents and young adults face in dealing with the violence in their parents' marriage. Without putting unreasonable expectations or burdens on these adolescents to intervene with adult issues, their potential learning experiences about domestic violence in school may alert them to the dangers in their homes. Obviously, as part of these lessons, safety planning that does not endanger them or other family members has to be addressed.

Although we often think of adults worrying about the welfare of children, it is not unusual to find children and adolescents bringing home changing social attitudes and behaviours about smoking, drinking and driving, and polluting the environment. Domestic violence may be another such topic that leads to potentially life-saving discussions. In two of our cases, the children themselves became homicide victims. In several other cases, it appears they might have been targets who were spared only by fortuitous circumstances. In these homes, domestic violence and safety planning was as essential as learning about fire, traffic, or water safety.

Assessment and Intervention

10. **There is a need to have appropriate assessment tools available to those who work with victims and perpetrators of domestic violence to better assess the potential for lethal violence in their lives. Correspondingly, once the risk is identified, victims and perpetrators of domestic violence need access to appropriate services and programs. The person at risk requires access to:**

    - **a specialized and comprehensive risk assessment by an appropriate agency;**
    - **skilled assistance to engage the victim in developing a safety planning process; and**
    - **risk management, for both the victims and the perpetrator.**

In a particularly tragic case of multiple-homicide, the recently estranged spouse had prepared an extensive narrative of past emotional and physical abuse against her and their children, as well as unfounded paranoid threats against two third parties. One of the third parties was later murdered on the same night as the estranged spouse, and an attempt was made on the life of the other by the perpetrator. The perpetrator later died at the end of a police chase when he crashed the vehicle he was driving. The detailed narrative had been provided to the police, at their request, after the accused had been arrested. However, he was released after he had a bail hearing. No apparent assessment was made of the information, nor was it used even after it was known that he was continuing to harass his estranged spouse and violating the terms of release.

11. **All victims experiencing any form of domestic violence should be referred to and directly involved in a safety planning process whenever abuse is disclosed to social workers/counsellors, shelter, or other services for abused persons, such as physicians, the police, and victim services.**

Notwithstanding the need for safety planning seen in a number of the cases, the victim was provided with safety planning information in only one case. In that one instance, the victim visited a resource centre for abused women in a distant community with the assistance of her sister. She received information to assist her in dealing with the abuse and how to go about safety planning.

12. **It is recommended that each police service appoint an appropriate number of officers, specially trained in the issues of domestic violence, as case managers. The case managers' duties would include reviewing all domestic violence cases, identifying—i.e., "red flagging"—any high-risk matters, and tracking the cases as they proceed to completion.**

13. **All front-line professionals that deal with individuals and families in crisis should adopt an appropriate risk assessment process and a mechanism or protocol at a local level to facilitate and enhance communication between**

agencies and professionals when a person is identified to be at risk. For example, such a protocol should permit any professional evaluating a high-risk case to contact the local police service's case manager or domestic violence coordinator to establish a case conference to ensure appropriate tracking and response to the case.

In one particular instance, after the bail court had dealt with the matter involving the perpetrator, the victim at the request of the police completed a "dangerousness assessment in domestic violence" questionnaire. The responses contained sufficient information about prior abuse and threats to the victim and others to make it a high-risk case. After his release, the perpetrator continued to harass the victim and repeatedly breach the terms of his recognizance, most of which was reported to the police service involved in the original complaint. If a case manager or domestic violence case coordinator had been assigned, the continuing complaints about the perpetrator's alleged breaches may have been dealt with differently and with greater attention, particularly if assessed by one officer possessing all of the information reported to the police service.

14. There is a need for greater use of case conferencing systems that share information and action plans between justice partners, health professionals, and counsellors regarding safety issues and "high risk" cases.

Many cases the committee reviewed had multiple community agencies and professionals involved who held important information about the case, but had no formal mechanism to share that information. Had they known the totality of the information, there might have been a more effective response to ensuring the safety of the victim? All professions need to explore ways that permit their practitioners to participate meaningfully in case conferencing opportunities while respecting privacy and confidentiality constraints.

15. It is recommended that every effort be made by family members, friends, and community professionals to have firearms removed from individuals who are going through a separation in their relationships and showing signs of depression or suicidal or homicidal ideation.

Access to firearms is an important risk factor. Moreover, restricting access to firearms is important in terms of effective intervention and risk management. Four of the eleven cases reviewed involved the use of firearms and situations where family members and friends were aware it was not in the perpetrator's interest to possess them due to mental and/or emotional issues during a time immediately preceding the homicides. It is also well established that the time of separation can be the most dangerous time, and in all of the cases involving the use of firearms, the homicides occurred shortly after separation or in anticipation of it occurring.

16. **Every community where a domestic violence related homicide takes place should be supported to undertake a community-based education process focusing on prevention. It is recommended that a central provincial resource be identified to provide resources, support, and expertise to assist that community to use the tragedy as a catalyst for action. Ensuring that members of the local community take the lead in planning the educational process, the provincial government should provide necessary assistance, such as funding for public education materials, meetings, and other public awareness events. This provincial response to each domestic violence homicide would ensure that each community is supported in creating its own unique response that promotes collective awareness of spousal and child abuse, and can help make a difference in the prevention of future deaths.**

Resources

17. **All of the above recommendations require adequate resources to ensure victim safety and reduce perpetrator risk. They address the lack of programming and services, and the recognition that all programming and services require the necessary resources to become operational. These resources include, but are not limited to:**

    - **support for helping the victim to be removed from the situation if appropriate;**
    - **affordable alternative housing;**
    - **counselling services for victims and families; and**
    - **other community and culturally based support systems and services for victims, perpetrators, and children exposed to domestic violence.**

    It is obvious that the demand for these resources will increase with better risk assessments, interventions, and risk management strategies.

Information is the necessary resource to ensure the effectiveness of the DVDRC. The more information available to the DVDRC about the circumstances of the victims and perpetrators, the better the committee will be able to:

- identify systemic issues, gaps, and shortcomings;
- establish a comprehensive database; and
- identify trends, patterns, and risk factors for prevention.

18. **It is recommended that a protocol be established for the complete investigation of domestic violence fatalities where the facts involve both homicide and suicide.**

In 64% of the cases reviewed by the committee, the perpetrator subsequently took his own life. Because such cases do not generally give rise to criminal charges, the police may not investigate the deaths as thoroughly as they would if charges were to occur,

notwithstanding the fact that the police use a major case management investigation model for the cases. The committee has had the benefit of some very thorough investigations for its work. However, some cases were not investigated to completion, leaving the committee uncertain as to the actual facts of the related deaths. The committee is dependant on a complete set of facts for each investigation to extract the lessons that may be learned from each case to make recommendations to prevent deaths in similar circumstances. The committee suggests that an investigative protocol be established requiring all homicide/suicides be as completely investigated as those leading to criminal charges. Such an approach will assist in the community's efforts to better understand the root causes of domestic violence, the best course, and practices for its prevention.

Clarification:

In the Appendix B to last year's report, in the article *Domestic Homicides: Critical Issues in the Development of Death Review Committees*, the reference "the Hadley jury noted that, despite Ralph Hadley being assessed as high-risk, the perpetrator was granted bail" was with respect to the assessment of the inquest jury and the police officer involved who predicted "dire consequences" if Ralph Hadley was to be released based on her assessment of Hadley's behaviour and prior history. In fairness to all the professionals in the justice system, not all those engaged in the bail proceedings made similar findings based on the information available to them.

Office of the Chief Coroner

Province of Ontario

26 Grenville Street

Toronto, Ontario

M7A 2G9